HOSPITALS

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Reorganizing the Nursing Service

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Focus on Tomorrow's Hospital Costs

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The Journal of the American Hospital Association

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references:

1. A. W. Spittler, Col., (M.C.), U.S.A., J. J. Brennan, Lt. Col., (M.C.), U.S.A., J. W. Payne, Capt., U.S.A.F. (M.C.), American Academy of Orthopedic Surgeons, Jan. 26-31, 1952, Chicago, Illinois.
2. M. C. Cobey, M.D., F.A.C.S., Professor of Orthopedic Surgery, Georgetown University and Senior Attending Orthopedic Surgeon, Children's Hospital, Washington, D.C., The American Surgeon, Vol. XVIII, No. 4, April, 1952, pp. 413, 415.
3. M. C. Cobey, M.D., F.A.C.S., Washington, D.C., private communication.

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3. Pneumococci	Empyema, lobar pneumonia
4. Corynebacterium diphtheriae	Diphtheria carriers
5. Nonhemolytic streptococci	Some cases of endocarditis, genito-urinary tract infections

*References

1. Heilman, F. R., Herrell, W. E., Wellman, W. E., and Geraci, J. E.: Some Laboratory and Clinical Observations on a New Antibiotic, Erythromycin ('Ilotycin'), Proc. Staff Meet., Mayo Clin., 27:285 (July 16), 1952. 2. Haight, T. H., and Finland, M.: Laboratory and Clinical Studies on Erythromycin, New England J. Med., 247:227 (August 14), 1952. 3. Smith, J. W., Dyke, R. W., and Griffith, R. S.: Erythromycin: Studies on Absorption Following Oral Administration and on Treatment of 33 Patients, to be published. 4. Spink, W. W.: Personal communications. 5. Romansky, M. J.: Personal communications.

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HOSPITALS

IN THIS ISSUE

FEBRUARY • 1953

The Journal of

THE AMERICAN HOSPITAL ASSOCIATION

VOLUME 27 NUMBER 2

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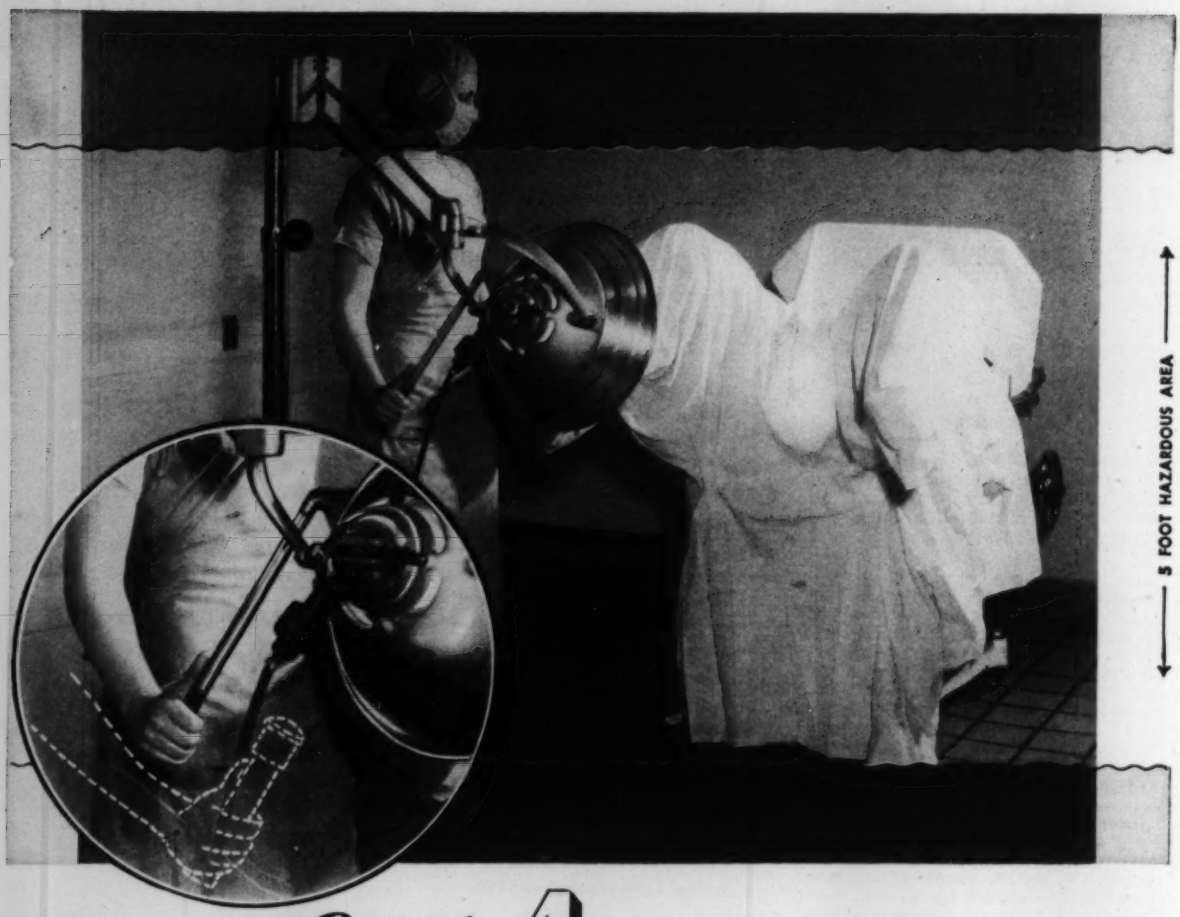

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Midyear Conference of the American Hospital Association—February 6-7; Chicago (Drake Hotel).

55th Annual Convention—August 31-September 3; San Francisco.

REGIONAL MEETINGS

Association of Western Hospitals—April 27-30; Salt Lake City (Utah Hotel).

Middle Atlantic Hospital Assembly—May 20-22; Atlantic City (Convention Hall).

Mid-West Hospital Association—April 15-17; Kansas City, Mo. (Municipal Auditorium and President Hotel).

New England Hospital Assembly—March 23-25; Boston (Statler Hotel).

Southeastern Hospital Conference—April 8-10; New Orleans (Jung Hotel).

Tri-State Hospital Assembly—May 4-6; Chicago (Palmer House).

Upper Midwest Hospital Conference—May 13-15; Minneapolis (Radisson Hotel).

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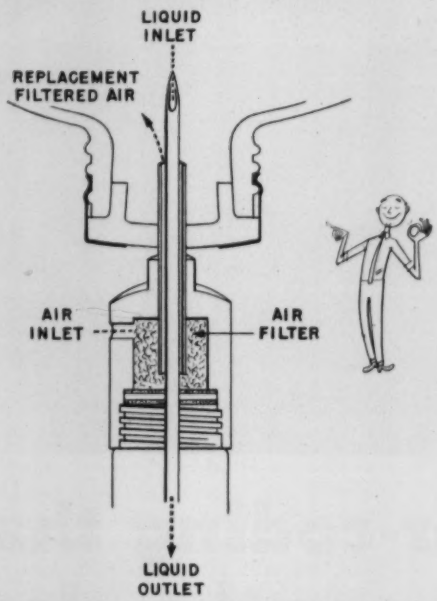

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STATE MEETINGS

Alabama—March 12-13; Montgomery (Jefferson Davis Hotel).

Arizona—February 12-14; Phoenix (Adams Hotel).

Georgia—February 20-21; Atlanta (Atlanta-Biltmore Hotel).

Kentucky—March 24-26; Louisville (Seelbach Hotel).

New Jersey—May 20-22; Atlantic City (Convention Hall).

New Mexico—May 22-23; Albuquerque (Hilton Hotel).

New York—May 20-22; Atlantic City (Convention Hall).

Ohio—April 6-9; Cincinnati (Netherland-Plaza Hotel).

Pennsylvania—May 20-22; Atlantic City (Convention Hall).

Tennessee—May 8-10; Nashville (Andrew Jackson Hotel).

Texas—May 12-14; Galveston (Buccaneer Hotel).

Washington—April 8; Spokane (Davenport Hotel).

Wisconsin—February 19; Milwaukee (Schroeder Hotel).

OTHER MEETINGS

American Association of Medical Record Librarians—October 5-9; San Francisco (Palace Hotel).

American Protestant Hospital Association—February 10-13; Chicago (Palmer House).

Canadian Hospital Council — May 18-20; Ottawa (Chateau Laurier).

International Hospital Federation—May 25-30; London, England.

National Association of Methodist Hospitals and Homes — February 11-12; Chicago (Palmer House).

INSTITUTES

(For additional information address Association headquarters, 18 E. Division Street.)

Institute on Hospital Planning—February 9-13; San Francisco (Sir Francis Drake Hotel).

Institute on Personnel Relations—March 2-6; Garden City, L. I., N. Y. (Garden City Hotel).

Institute on Dietary Department Administration—March 9-13; Chicago (Sheraton Hotel).

Institute on Anesthesia—March 9-13; Dallas (Adolphus Hotel).

Institute on Nursing Service Administration—March 16-20; Washington, D.C. (Wardman-Park Hotel).

Institute on Hospital Engineering—April 6-10; Washington (Wardman-Park Hotel).

Institute on Public Relations (in conjunction with Southeastern Hospital Conference)—April 6-7; New Orleans (Sung Hotel).

Institute on Medical Record Administration—March 30-April 3; New Haven (Yale University).

(Continued on page 145)

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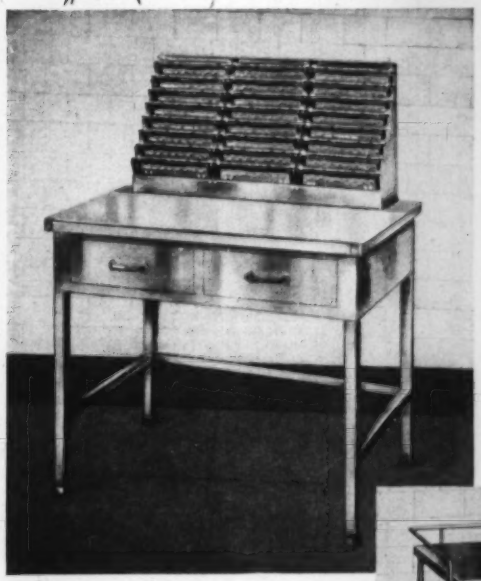

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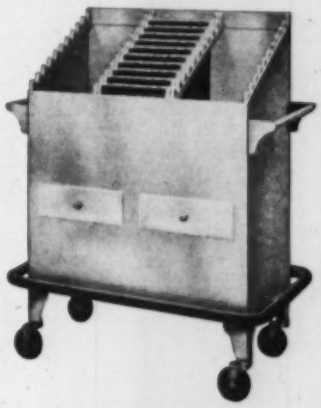

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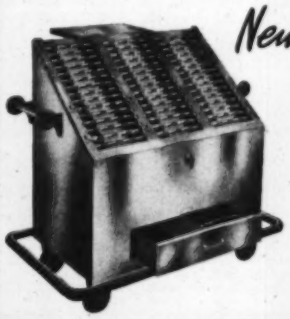

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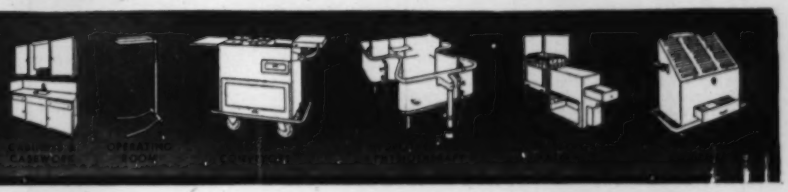

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Abraham Oseroff, *treasurer*, Hospital Service Association of Pittsburgh, Pittsburgh 22
E. Dwight Barnett, M.D., Columbia University School of Public Health, New York 32
Arthur M. Calvin, Minnesota Hospital Service Association, St. Paul 4
M. Haskins Coleman Jr., Virginia Hospital Service Association, Richmond 19
Robert T. Evans, Blue Cross Plan for Hospital Care, Chicago 90
Roger W. Hardy, Massachusetts Hospital Service, Boston 6
N. D. Helland, Group Hospital Service, Tulsa 3
John R. Hill, Tennessee Hospital Service Association, Chattanooga 2
Basil C. MacLean, M.D., Strong Memorial Hospital, Rochester 7
Carl M. Metzger, Hospital Service Corporation of Western New York, Buffalo 2
D. W. Ogilvie, Blue Cross Plan for Hospital Care, Toronto 5
Louis H. Pink, Associated Hospital Service of New York, New York 16
Rt. Rev. Msgr. George Lewis Smith, Director of Catholic Hospitals, Diocese of Charleston, Aiken, S. C.
Richard M. Jones, *director*, 425 N. Michigan Avenue, Chicago 11

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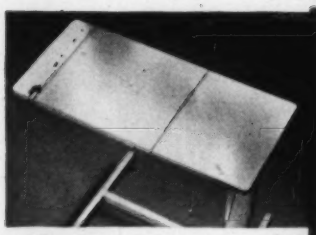
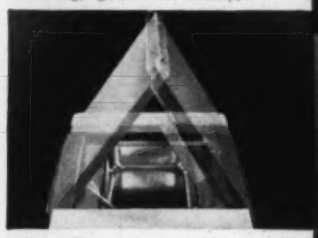
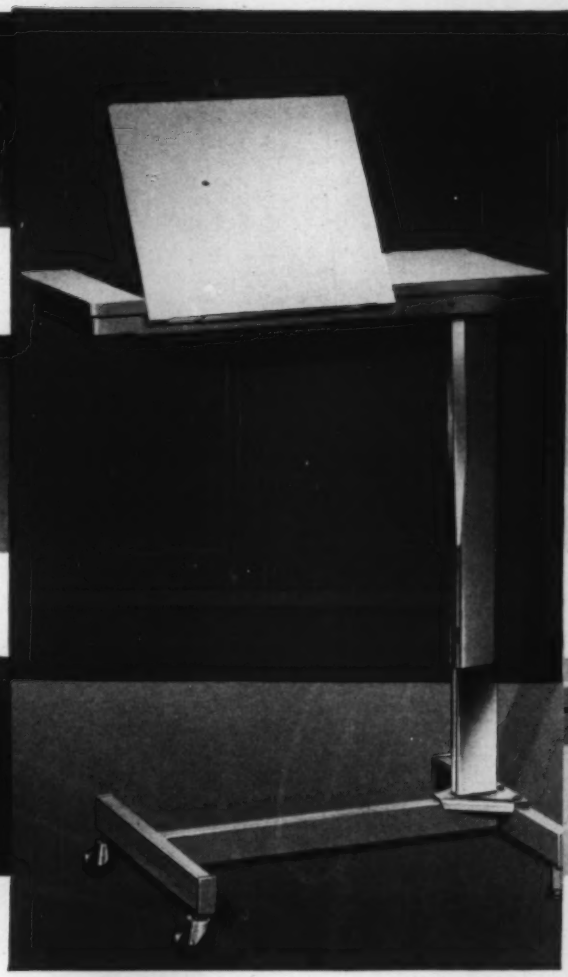


Ever see such a *big* top on an overbed table? 14¼ x 31¼ inches! Its 5-ply laminated base is covered with tan and grey Zalmite. Resists damage by heat, cold and spilled liquids.

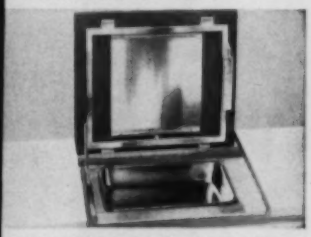
Note the balanced spread of this sturdy base. And the extra bracing clamp where base meets pedestal upright. Note, too, that base is equipped with casters for easy moving; glides for stability.



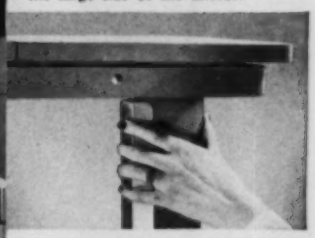
Double hinged center-section permits full use of table from either side of the bed. Patient has advantage of using full section as book or magazine rest, and of a larger mirror when used as a vanity.



The full width, movable center section will hold a large magazine or a folded newspaper. Note the flat surface area at right of rack, ample for articles in use when center section is raised.



This big stainless steel tray gives the patient room for personal articles, writing materials, etc. This tray is also available finished in porcelain enamel (F-884). Note, the large size of the mirror.



To raise or lower, patient simply presses on hand grip, and the counterbalanced table top adjusts to one of 15 positions, graduated 1 inch apart. Can be lowered to 29¼"—for use by patient seated in chair.

Only Simmons Overbed Table has all these features!

Illustrated here are the 6 outstanding features of Simmons new single pedestal overbed table—F-885. *Compare it with any other table.* You'll soon see why we say it offers more value in construction features, sturdiness, utility and quality.

See this new, improved Simmons Overbed Table at your hospital supply dealer's showrooms, or at any of the Simmons display rooms whose addresses are listed below. Or, write today for complete details, including quantity prices.

SIMMONS COMPANY
HOSPITAL DIVISION

Display rooms:

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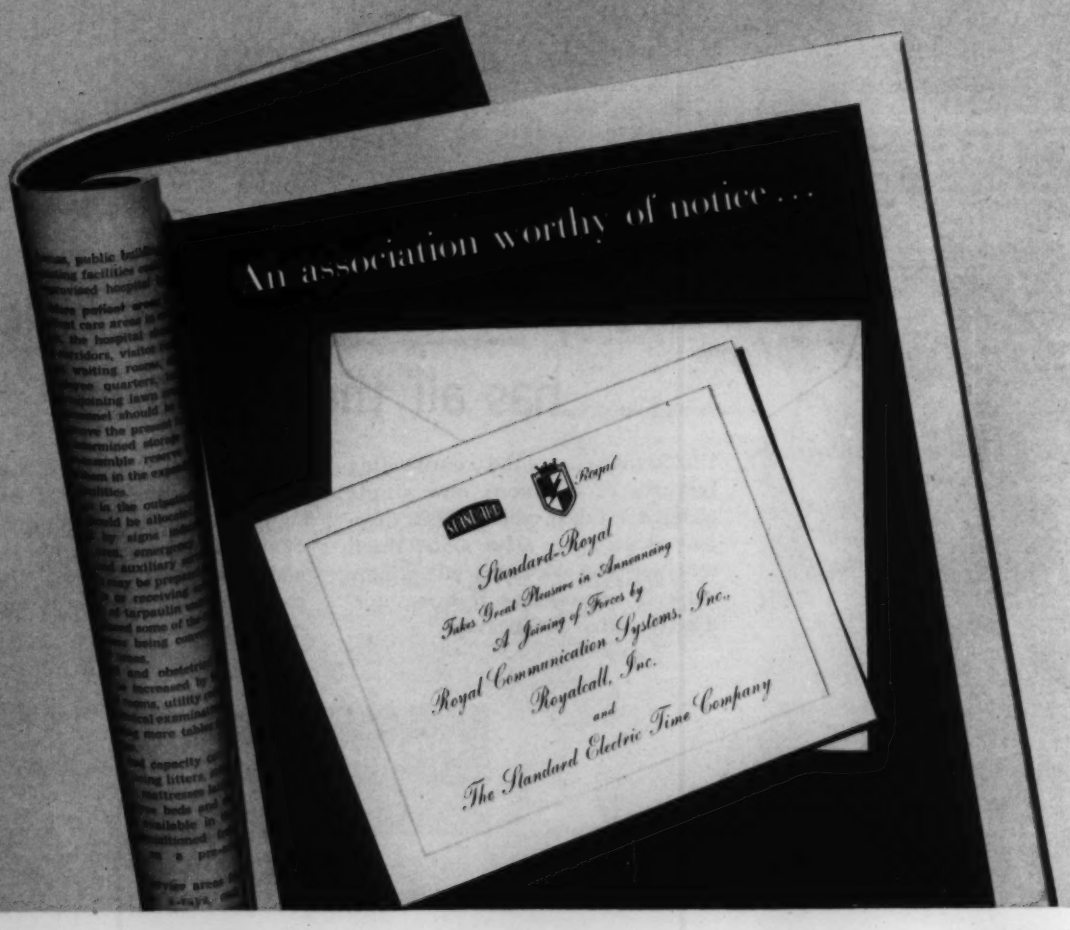
To our friends...

We would like to thank our many friends who have sent congratulations on the joining of forces recently announced by STANDARD-ROYAL. All of us in the STANDARD-ROYAL organizations have been deeply gratified to receive your kind messages.

This association will place a national sales and service network behind the distribution of hospital signal and communicating systems. We invite you to inquire how these outstanding systems—as modern as tomorrow—will "bring your hospital up to STANDARD."

THE STANDARD ELECTRIC TIME COMPANY
81 LOGAN STREET, SPRINGFIELD 2, MASSACHUSETTS



From bees wax and bubbles

TO GINGERBREAD...

From the dark, close "sick room" days of crudely glazed windows of bubbly glass and bee's wax, to more recent days of airless, sunshineless thick leaded panes... progressive medical men have crusaded for better windows.

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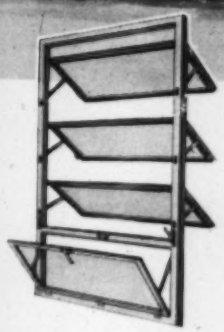
LUDMAN Auto-lok AUTOMATIC LOCKING PATENTED **ALUMINUM WINDOWS**

Here, at last, are windows perfectly engineered and designed to meet the requirements of hospitals... for easily and quickly controlled ventilation... for walls of windows that let in beneficial sunshine, but close *ten times tighter* to keep out cold DRAFTS—saves heating costs, too... or, conserves air-conditioning expense.

Along with AUTO-LOK's tremendously important features of controlled ventilation and positive tight closure, the added convenience of "one-hand" operation is a great boon to busy hospitals.

Easy maintenance... all glass can be cleaned from inside... top vent, too! Easiest to operate ... guaranteed for a lifetime of trouble-free service. Maintains tight closure without regular adjustments essential in ordinary awning or other windows.

Select the only windows of today that meet the demands of the future! Write us for complete information.



No more stuffy, humid rooms when it rains. Rain won't come in through Auto-Lok's slanting vents!

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You can be *sure*

WITH THIS SPONGE

sure of lower cost for post-operative dressings, with

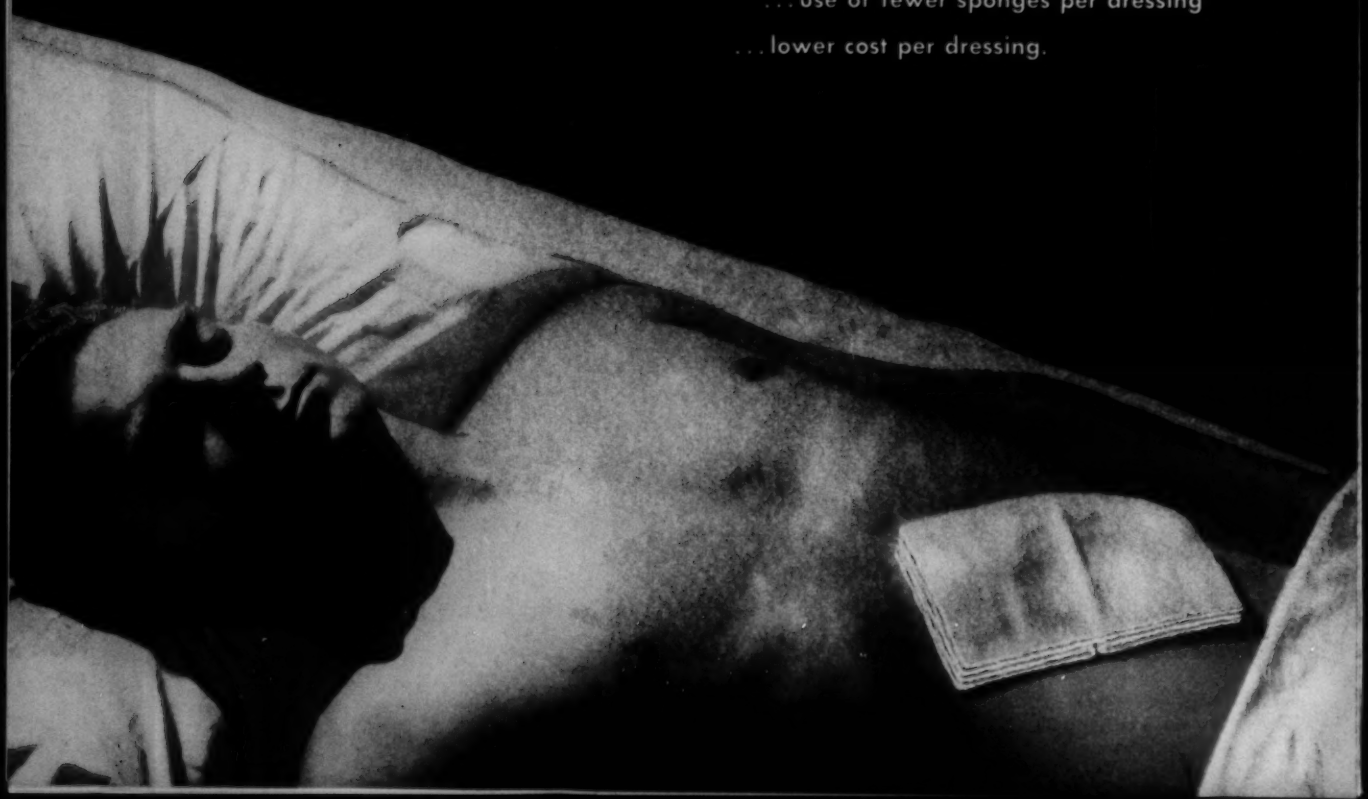
ZOBEC

cotton-filmated **SPONGES**

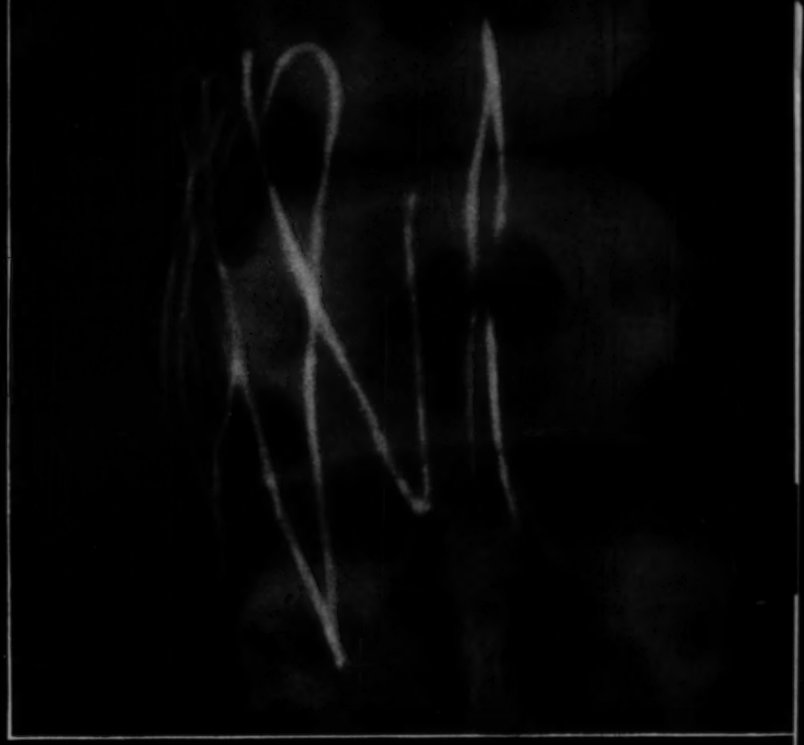
Extra bulk and fluff of Zobec sponges mean

. . . use of fewer sponges per dressing

. . . lower cost per dressing.



E COMBINATION



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detection, if
a sponge is "lost", with

RAY-TEC

X-ray detectable **SPONGES**

The unmistakable string pattern
covers wide area on X-ray plate.
All parts of sponge are
soft, pliable, non-abrasive.
Black monofilament identifies
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HOSPITAL DIVISION

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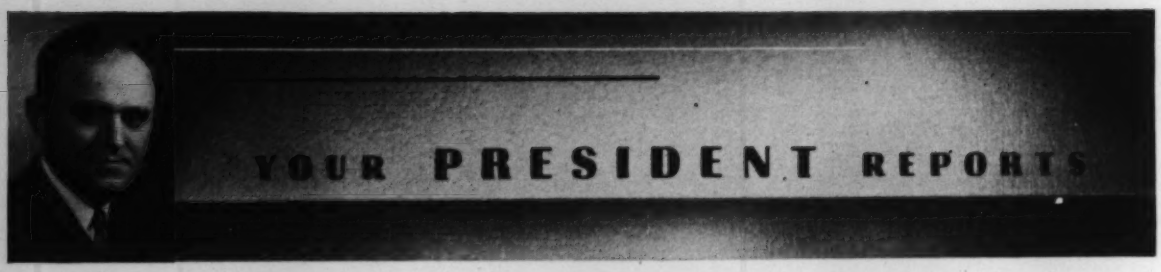

SOMETIME DURING the year-end holidays you should have received a copy of a new American Hospital Association leaflet entitled, "To Preserve and Restore Health," which I recommend for your careful review. It contains the Association's platform, which was first adopted in 1944 and confirmed later in 1950. The leaflet also outlines the A.H.A.'s comprehensive program to bring the "ideas and ideals of its members into focus" in order to "improve the quality and distribution of hospital care." A thorough reading of this leaflet will reconfirm these points in your mind.

ALTHOUGH FEBRUARY is the shortest month of the year, it is the birthday month of two of our greatest Presidents: George Washington and Abraham Lincoln. And speaking of presidents reminds me that during the holidays I received an interesting New Year's card from A.H.A. President-elect Ritz Heerman. In addition to a kind and thoughtful personal greeting, his card served as a pertinent reminder that 1953 would bring a new year, a new administration in Washington and, come September, a new American Hospital Association prexy. Thank you kindly, Ritz.

DIACK

DEPENDABLE SERVICE SINCE 1909

Increasing Popularity of Diack Controls is shown by 1952 sales exceeding 1940 sales *seven times over.*

Diack Controls
1847 NORTH MAIN STREET ROYAL OAK MICHIGAN

SMITH AND UNDERWOOD
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Diack Controls and Inform Controls

THE COMMITTEE on Careers in Nursing, which is actively concerned with the recruitment of student nurses, has, for the past several years, been supplying hospitals with highly effective campaign materials.

Spot surveys, however, have disclosed the fact that many schools are not taking full advantage of these recruitment aids. Certainly they warrant studied appraisal by the administrator and the director of nursing, both of whom have been receiving them from the committee. Have you used any of this material at your hospital as yet?

While a recent study revealed that schools of nursing continue to recruit the same proportion of 17½-year-old students, we must not forget that the drop-out rate of these students is abnormally high. In 1947, for example, more than one-third of the students recruited dropped out before they completed their training. This is an annual loss of more than 10,000 potential nurses.

In addition, it is startling to realize that of every 100 girls who enter schools of nursing, only 38 will be actively engaged in that profession five years after beginning training, and only 29 will be practicing nursing eight years after they initially enter school.

There are many things we can do to solve the problems of the shortage of nurses, but let us never forget that the first thing we must do is recruit students. One sure way to do it is to use the committee's excellently prepared materials in your hospital's student nurse recruitment campaigns.

WATCH FOR information on the National Blood Program and when you receive it, read it and study it carefully. This program is an at-

a free-flowing
aqueous repository penicillin
which does not
require refrigeration

Flo-Cillin Aqueous

crystalline procaine penicillin G 300,000 u/cc. in aqueous suspension.

Bristol's free-flowing aqueous suspension of penicillin for repository injection requires no refrigeration.

Always ready for instant use, Flo-Cillin Aqueous can be stored in the office cabinet, on the pharmacy shelf, or carried in the physician's bag for one year with no loss of potency or physical change.

no diluent to add
outstandingly fluid
a stable, uniform suspension

Available in 10 dose vials, 1 dose vials, and disposable syringe packages.

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SYRACUSE, NEW YORK

ALL YOUR NEEDS FROM *ONE* SOURCE OF SUPPLY

MILLS MILLS

Gathered together under one roof are all the needs for servicing a hospital, from the basic necessities to the many comfort-making accessories . . . all designed to help you build prestige and good-will.

Whatever your needs, whatever the quantity, MILLS has them for you. All products are made of finest quality materials in modern, easy-to-clean designs, tested for guaranteed satisfaction.

Mills Hospital Supply Company

6626 North Western Avenue

Chicago 45

tempt at the national level to consolidate the work of the many groups which are interested in the gathering of blood for defense purposes. Incidentally, we have been assured that this program will not interfere in any way with the operation of blood banks for current civilian needs.

Recent decisions to use gamma globulin for the prevention of poliomyelitis magnify the importance of the National Blood Program. It is estimated that more than two million children will be exposed to the disease in next year's epidemics. Even with a seven-day week and a 24-hour processing schedule, the supply of gamma globulin will not meet the demand at the height of the poliomyelitis season next summer.

The American Red Cross has agreed to finance extraction of gamma globulin from whole blood and the National Research Council has appointed an advisory group to supervise the allocation of it. The cooperative National Foundation for Infantile Paralysis is also playing a major role in the planning for its use.

These accomplishments have been made through the exemplary work of the committees serving the National Blood Program. I urge everyone to support this significant project.

THE BLUE CROSS Commission issued its report last December for the first nine months of 1952, and it is most encouraging. The report shows that the Blue Cross will pay more than a half billion dollars to hospitals for services to be rendered nearly 43 million subscribers in 1953.

This, however, is not enough. Hospitals must concern themselves with the millions of persons who, as yet, have no form of prepaid hospital insurance. They are our responsibility, too.

In Cleveland, recently, a positive attempt was made to do something about this problem. Before they left the various hospitals in the city, all persons who did not have hospitalization insurance learned about its advantages from a hospital representative. Those who were interested were enrolled in the Blue Cross Plan on the spot.

In that way, the hospitals are aggressively doing their part. I think it's a fine idea.

EQUALLY EFFECTIVE and inspirational was a vigorous enrollment campaign conducted in Garrard County, Ky., where nearly half —45 per cent—of the population was signed up in a spirited drive undertaken by scores of hospital volunteers. This is another—and most practical—way to use their invaluable assistance.

Although there has been some successful experimentation with disaster and catastrophe coverage —the Health Service, Inc., for instance, has made this type of protection available—the surface has only been scratched in this important area.

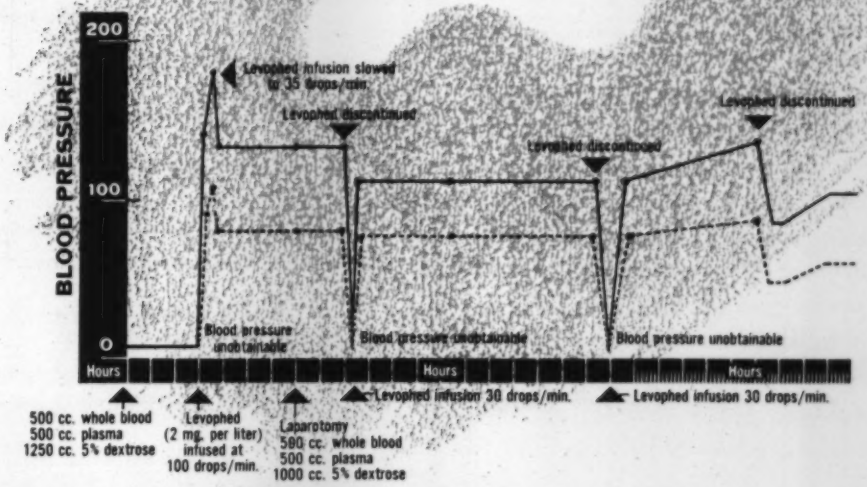
Meanwhile, every imaginative idea, every possible effort and all available resources should be utilized to bring the tremendous benefits of membership in Blue Cross plans and other organizations offering prepaid hospital insurance to more and more currently unprotected members of our communities. Remember, each one of them is a potential patient at our hospital. Let us make sure that when he enters our doors, he has the service benefits that go with Blue Cross membership.

Edwin L. Crosby

Edwin L. Crosby, M.D., President
American Hospital Association

New...

The Most Powerful Pressor Antidote for SHOCK



LEVOPHED®

BRAND OF LEVO-ARTERENOL (NOR-EPINEPHRINE)

Prompt, Predictable, Reliable, Easily Controlled Action

Clinical experience with Levophed has demonstrated the dramatic, often life-saving action of the drug.

Levophed is indicated for the elevation and maintenance of blood pressure during all stages of shock, including profound, advanced, prolonged and so-called "irreversible" shock, as well as other acute hypotensive states associated with surgical and non-surgical trauma, hemorrhage, disease and central vasomotor depression.

SUPPLIED: Levophed solution 1:1000 in ampuls of 4 cc. (boxes of 10), to be administered in 1000 cc. of infusion fluid.

Write for pamphlet giving a detailed discussion of clinical experience with Levophed and its manner of use.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Levophed, trademark reg. U. S. & Canada

The New Colson® Inhalator

provides safe, convenient and *effective* treatment of respiratory diseases

The new COLSON Inhalator provides the most satisfactory method of administering vaporization or inhalations in the treatment of respiratory ailments. Its operation is simple, certain, effective and safe. Visible liquid supply lasts 16 hours on low heat, 8 hours on high. Trouble-free control prevents dangerous over-heating even if water supply becomes exhausted through oversight.

Features of New COLSON Model 4953 Inhalator

- Stainless steel boiler, reservoir, medicine cup and flexible tube.
- Visible water supply.
- Uninterrupted operation while replenishing water supply.
- Easy access to medicine container.
- Trouble-proof thermal switch to prevent damage if water supply is exhausted.
- High and low heat.
- No fuses or thermostats.
- Approved by Underwriters' Laboratories and Canadian Standards Association.

Model 4970 COLSON Inhalator Dolly provides complete portability—can be used either with new or previous model

THE COLSON CORPORATION

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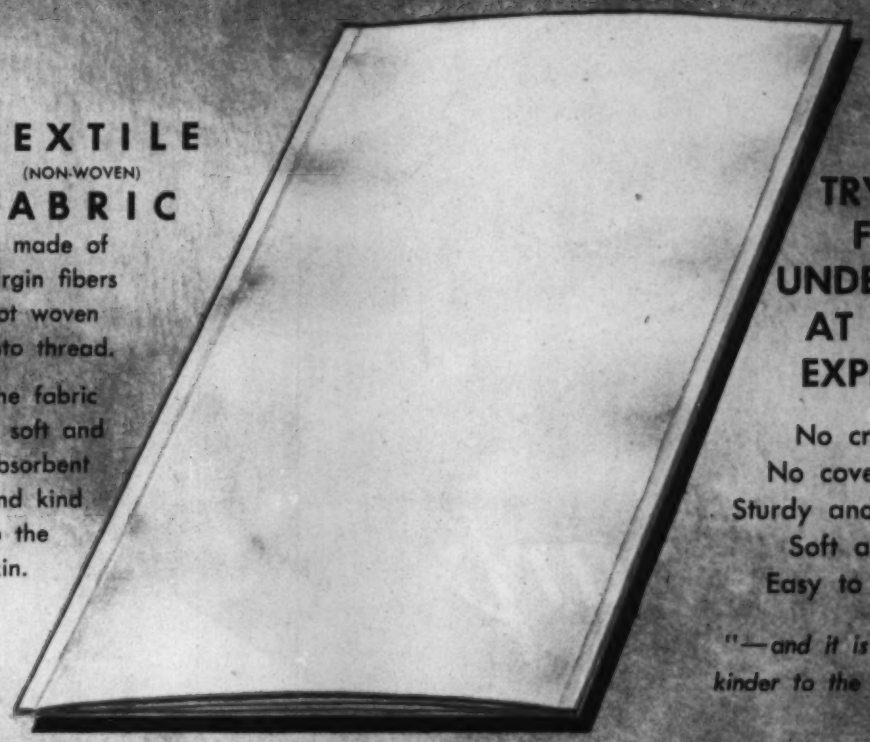
"DIANA-MADE FOR THE HOSPITAL TRADE"

A NEW

TEXTILE COVER (NON-WOVEN) UNDERPAD

TEXTILE
(NON-WOVEN)
FABRIC
is made of virgin fibers not woven into thread.

The fabric is soft and absorbent and kind to the skin.



TRY THIS FINE UNDERPAD AT OUR EXPENSE

No crumbling
No cover rattle
Sturdy and strong
Soft and cool
Easy to change

"—and it is so much kinder to the patient."

MAKE AN "ON-THE-BED" TEST AND SEE

Ask your Supply House Salesman for a test package. We'll gladly supply it.

All Diana products are sold and shipped under the label of your Hospital Supply House and are fully guaranteed.

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PROTECTIVE UNDERPADS
NEW 12" MATERNITY PADS

Full line of cellulose filled
HOSPITAL SANITARY NAPKINS

tells the story of B-P RIB-BACK BLADES

B-P RIB-BACK BLADES are the result of a constant endeavor to provide the surgeon with quality-controlled blades, having uniformly sharp and enduring cutting edges that he can depend on for maximum service performance. That is why . . . when you figure your blade purchases in terms of *true economy* . . . the answer is always "IT'S SHARP"—B-P Rib-Back Blades.

Ask your dealer

BARD-PARKER COMPANY, INC.
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IT ALL DEPENDS ON PERFORMANCE AND PERFORMANCE DEPENDS ON B-P RIB-BACK BLADES

No Fear, No Pain, No Memory

Now, there is a more humane approach to pediatric anesthesia. Eliminated is the unpleasant, too-familiar operating room "scene" with a frightened, fighting youngster. For with the rectal administration of PENTOTHAL Sodium, the child goes to sleep in his own bed *before* surgery—and wakes up there *after* surgery.

Rectal PENTOTHAL offers a relatively wide margin of safety. Controlled, individual dosages may be given to attain levels from preanesthetic sedation or hypnosis to basal anesthesia. When general anesthesia is desired, rectal PENTOTHAL reduces the dosage of inhalation agents. Emergence delirium and postanesthetic nausea are minimized. In many short, minor procedures, rectal PENTOTHAL may serve as the sole agent. Abbott

SEND FOR NEW BOOK

"... PENTOTHAL Sodium by Rectum." Thirty-six pages discussing the clinical value of PENTOTHAL by rectum for preanesthetic hypnosis and basal anesthesia—results from nearly 4000 cases. Write to Abbott Laboratories, North Chicago, Illinois.

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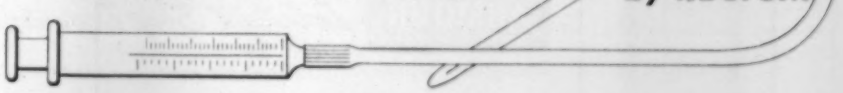
PENTOTHAL® SODIUM
(Thiopental Sodium, Abbott)
by RECTUM



Hexachlorophene in Dial Antiseptic Soaps assures faster scrub-ups, greater protection!

Even after you've gone through a conventional twenty-minute scrub-up, *your hands could be cleaner, Doctor!*

Tests have shown that the surgeon who uses a soap containing Hexachlorophene removes in only *three* minutes *ten times more* skin bacteria than does a conventional *twenty-minute* scrub-up, followed by a germicidal rinse.

Dial Liquid Antiseptic Soap was created by Armour to give you this greater safety factor – to provide you and your patients with more potent protection. Both the 20% and Concentrate Dial contain 5% Hexachlorophene, based on soap content – your assurance of truly effective germicidal protection. They are available in 5, 30 and 55-gallon steel drums.

DIAL Soap protects nurses and patients, too!

Hexachlorophene protection is available for nurses and patients in DIAL bar soap. With today's shorter hospital stays, many hospitals find it economical to provide the ¾-ounce guest size of DIAL for their patients' daily toilet. DIAL, even though it contains Hexachlorophene, *costs you no more* than ordinary soaps. It is available in ⅓, ¾, 1 and 2½-ounce sizes, both *wrapped* and *unwrapped*.

We recommend buying through your local Hospital Supply Jobber

ARMOUR *Industrial Soap Department*

Armour and Company • 1355 West 31st Street • Chicago 9, Illinois

With clean, convenient ice cubes or "cubelets"

Frigidaire Now Solves All Your Ice Supply Problems!

All you ever do is open the door and scoop out the ice you need . . . up to 200 pounds a day for as little as 26¢ a day!

Put an end to uncertain ice deliveries, impurities, costly, messy melting. With a Frigidaire Automatic Ice Cube Maker you always have plenty of sparkling clear solid ice cubes for cold drinks, chilling food and a hundred and one other uses.

Convenient bin stores about 100 lbs. of cubes or cubelets ready for use, and the supply is constantly replenished. No trays to fill or empty, no water to turn on or off, no extra handling. Attractive, flat-top cabinet. Uses little floor space. Fits under counters. Powered by famous Meter-Miser Compressor warranted for five years. Look for your Frigidaire Dealer in the Yellow Pages of phone book. Or write Frigidaire Division of General Motors, Dayton 1, Ohio. In Canada, Toronto 13, Ontario.

Two models make pure ice in two convenient forms:

New Ice "Cubelets" obsolete crushed, cracked, flaked ice

Tiny individual gems of ice only ⅝" square, thick or thin as you want them. Won't pack or lump together. Ideal for fountain drinks, salad pans, iced cups and ice packs.

Regular size Solid Ice Cubes— no holes, no odd shapes

Crystal-clear, mineral-free, solid ice all the way through—1¼" x 1⅛" x desired thickness, just right for cooling water, mixed drinks and every ice cube need.

Frigidaire *Ice Cube Makers*

The most complete refrigeration and air conditioning line in the industry

SERVICE FROM HEADQUARTERS

Operating room visitors

We have two doctors who believe they have a legal right to have visitors in the operating room. They do not ask permission from the patient or the patient's relatives, and they do not inform the office. The visitors vary from the county attorney, the local undertaker to the doctor's office girl.

I have read of a number of cases in which the physicians and hospitals were sued together and separately for this type of thing. Where do the hospitals stand on this issue? Is it all right if the surgeon demands that he has the right to have visitors in the operating room?

The decided legal cases do support your belief that visitors should not be permitted in the operating room while an operation is under way. Particularly is this true where the patient's consent has not been obtained. Even with the consent of the patient, however, the hospital is entirely within its right in excluding from the operating room all who are not participating in the operation.

The surgeon does not have any jurisdiction on the matter of who shall be permitted to attend the operation. He, himself, only practices in the operating room as a privilege granted to him by the board of trustees of the hospital. He may, on occasion, bring in outsiders—for example, his office nurse or secretary for the purpose of recording the operation—but he can do so only with the permission of the administration of the hospital.

It is no defense in law for the hospital to plead that it did not know that a stranger was present at an operation or that it could not prevent his presence. The hospital administration is presumed to be in control of its premises at all times and, depending upon the circumstances, might be called upon to share the liability with the surgeon in case there was an action in damages for breach of privacy.

For further details, I would refer you to "Law of Hospital, Physician and Patient" by Hayt, Hayt and Groeschel, and "Doctor and Patient and the Law" by Regan.—DR. CHARLES U. LETOURNEAU.

Hospital membership dues

We are seeking ways and means of encouraging membership in our nonprofit hospital association so that we may have a definite amount of dollars coming into the treasury every year from membership dues. At one of our meetings the following plan was suggested and we are wondering if it has ever been used in hospitals or what objections there would be to its use. The plan, in short, is this:

Memberships would be solicited at $5 or $10 per year. The low amount is used to try and get a large number of the lower income people interested. Upon receipt of their dues, we would send them an appropriate membership card and set up a ledger card in the hospital office showing they paid their dues. These funds would be solicited on the basis that if this class of members were admitted to the hospital they would have their paid dues credited against their bill. This would be either on an annual or cumulative basis.

Upon receiving the dues the hospital would set aside a certain percentage as a reserve against which the credits would be charged.

We believe the amount of reserve could be determined by figures on admittances per one thousand of the population. The amount received in excess of the reserve would go into the general operating funds. We would appreciate any information you might give us regarding such a plan and your comments as to whether or not you would consider it practical.

Your suggestion that membership dues of $5 or $10 per year be established as credit against which the members might charge the cost of hospital care on a cumulative or an annual basis, is not unique. Actually, you are suggesting the establishment of prepaid hospital expense accounts for individuals who wish to subscribe to a common fund to be held by your hospital and paid out for the purchase of hospital care. This is the basis on which Blue Cross Plans operate.

History records a number of similar experiments by individual hospitals. Unfortunately, most of that experience has not proved successful from the point of view of the hospital. At most, such prepaid hospital expense funds provide the institution with temporary working capital. In the long run, the donors use hospital care equal to, or in excess of, the contribution they make. About the only money left for the hospital from such funds is that which, when originally deposited, was treated as a contribution by the donor. Such contributions are not in the majority when a program such as you describe is launched.

In my opinion, it would be more desirable for your membership committee to work actively with your local Blue Cross Plan for the enrollment in that plan of large numbers of the low income workers in your community. Promotion of the Blue Cross Plan in your community would provide dual advantages. It would relieve the hospital of financial liability for the maintenance of the prepaid hospital expense fund and it would make hospital care available to the low income workers at the time they most need your hospital's services.—MAURICE J. NORBY.

Management course

We have need for a management course on the department and subdepartment head levels. Do you have a course outline that we could use?

We do not have a specific outline which could be of value to you in planning a course for department and subdepartment heads. The Committee on Personnel Relations of the American Hospital Association has spent considerable time in studying the problem of training management people to do a more effective job. Our conclusion has been that it is impossible to prepare an outline or "packaged" program which could be used by all hospitals. Instead, we have conducted a series of workshops on supervisory training in human relations, and through this process it has been possible to develop an understanding of the need for training and certain guides for planning and conducting a continuing management program to meet specific needs in the individual hospitals.

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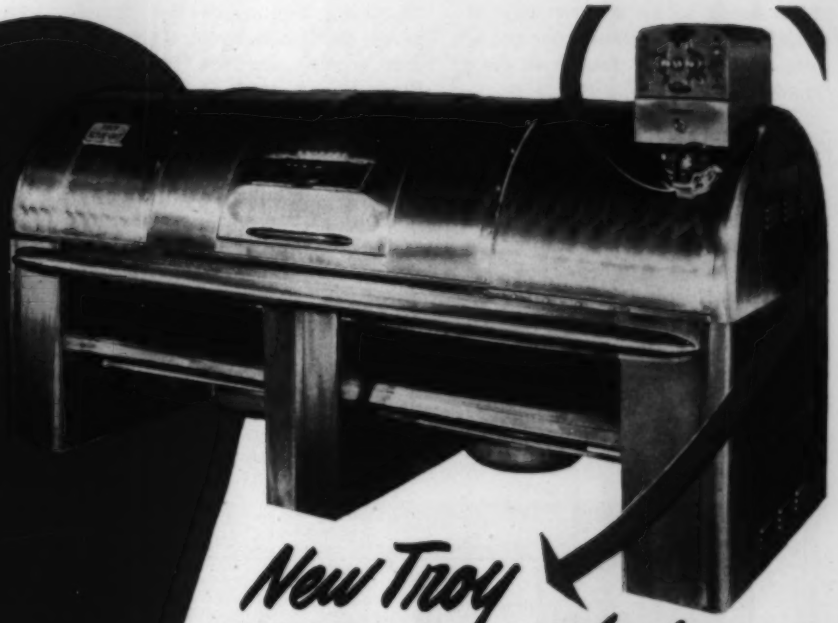

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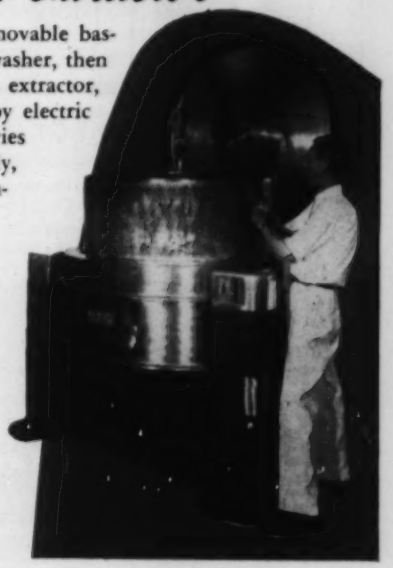

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There are several textbooks which might be of help to you in planning a management course. "The Development of Executive Talent," published by the American Management Association, is available in the library of the American Hospital Association on a loan basis, or may be purchased from the American Management Association, 440 West Forty-second Street, New York City. "Training Employees and Managers," published by McGraw-Hill, was written in 1950 by Planty, Eferson and McCord. This is an excellent book on the philosophy of training. "Management Development in Action" is another American Management Association publication and is number 148 of the Personnel Series. This document may be borrowed from the library of the American Hospital Association.

I am certain that you will find a wealth of information in these three books. You will find great emphasis placed on developing supervisory ability with methods suggested for planning your program.—ANN S. FRIEND.

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Also, if sterile water dispensers are to be used in the service room adjoining an operating room, it would seem logical to provide a dispenser for warm water as well as one for cold sterile water—ROY HUDENBURG.

Housekeeping advice

Is it customary to have a standing committee appointed from the medical staff to advise on housekeeping problems?

It is unusual to have a standing committee of this type appointed from the medical staff. It is customary, however, to appoint *ad hoc* committees to consider specific problems involved in housekeeping. Examples of such problems are methods for the control of dust, procedures in the cleaning of a room occupied by an infectious patient, types of chemicals used in laundering linens, disposal of infected dressings, painting the nursery, and a host of other problems that are too numerous to mention.

If a reorganization of housekeeping procedures is contemplated over a period of time, a standing committee might be more useful than a one-project committee. Otherwise, it seems to be the practice to appoint medical staff committees to deal with specific problems as they come up. — DR. CHARLES U. LETOURNEAU.

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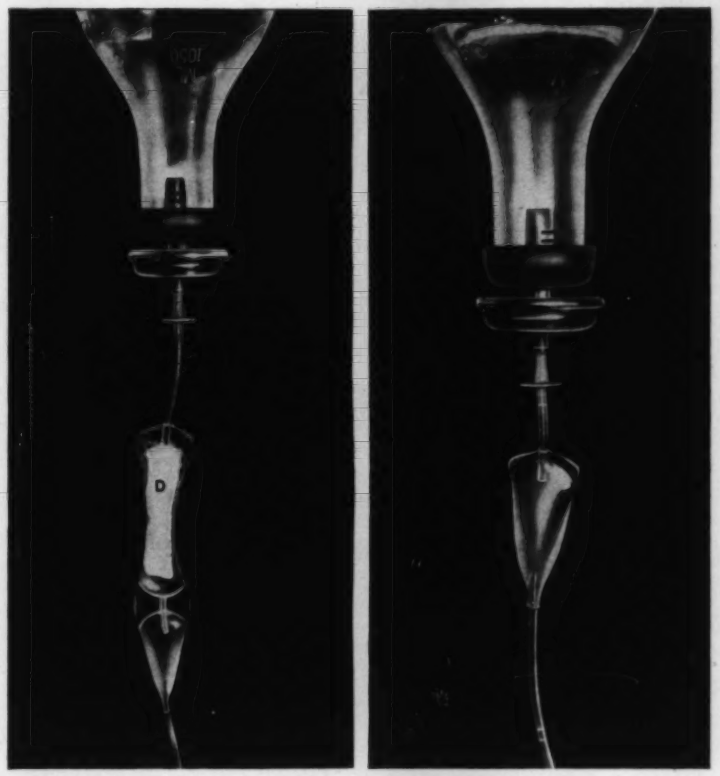

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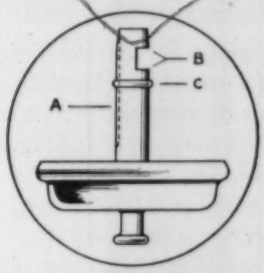

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*Sack, Theodore et al, The Preservation of Whole ACD Blood Collected, Stored, and Transfused in Plastic Equipment, Surg. Gyn. Obst. : 95, 113-119, 1952.
Walter, Carl, W., A New Technic for Collecting, Storage and Administration of Unadulterated Whole Blood. Surgical Forum.
Walter, Carl W., and Murphy, Wm. P. Jr., A Closed Gravity Technic for the preservation of Whole Blood in ACD Solution utilizing Plastic Equipment. Surg. Gyn. Obst.: 94, 687, 1952.

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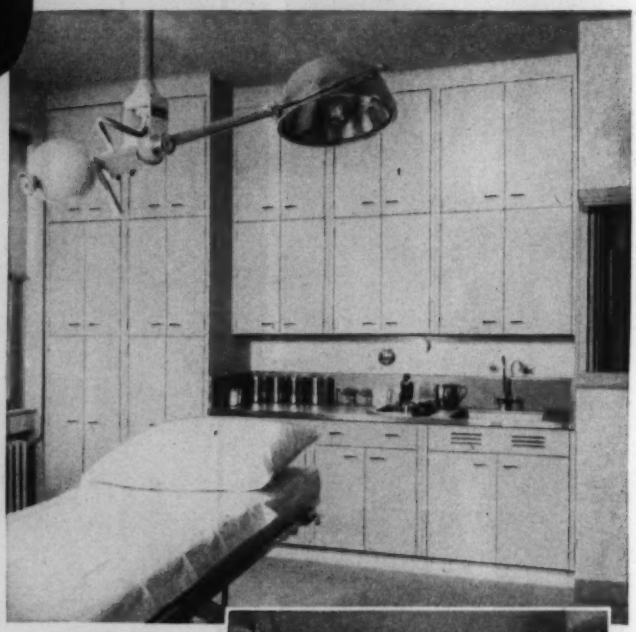

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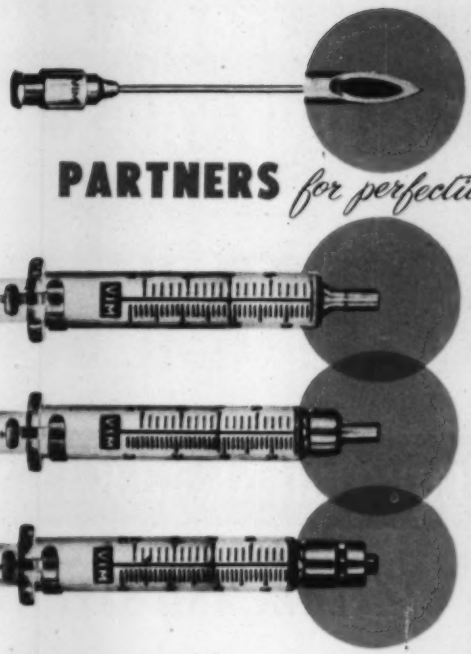

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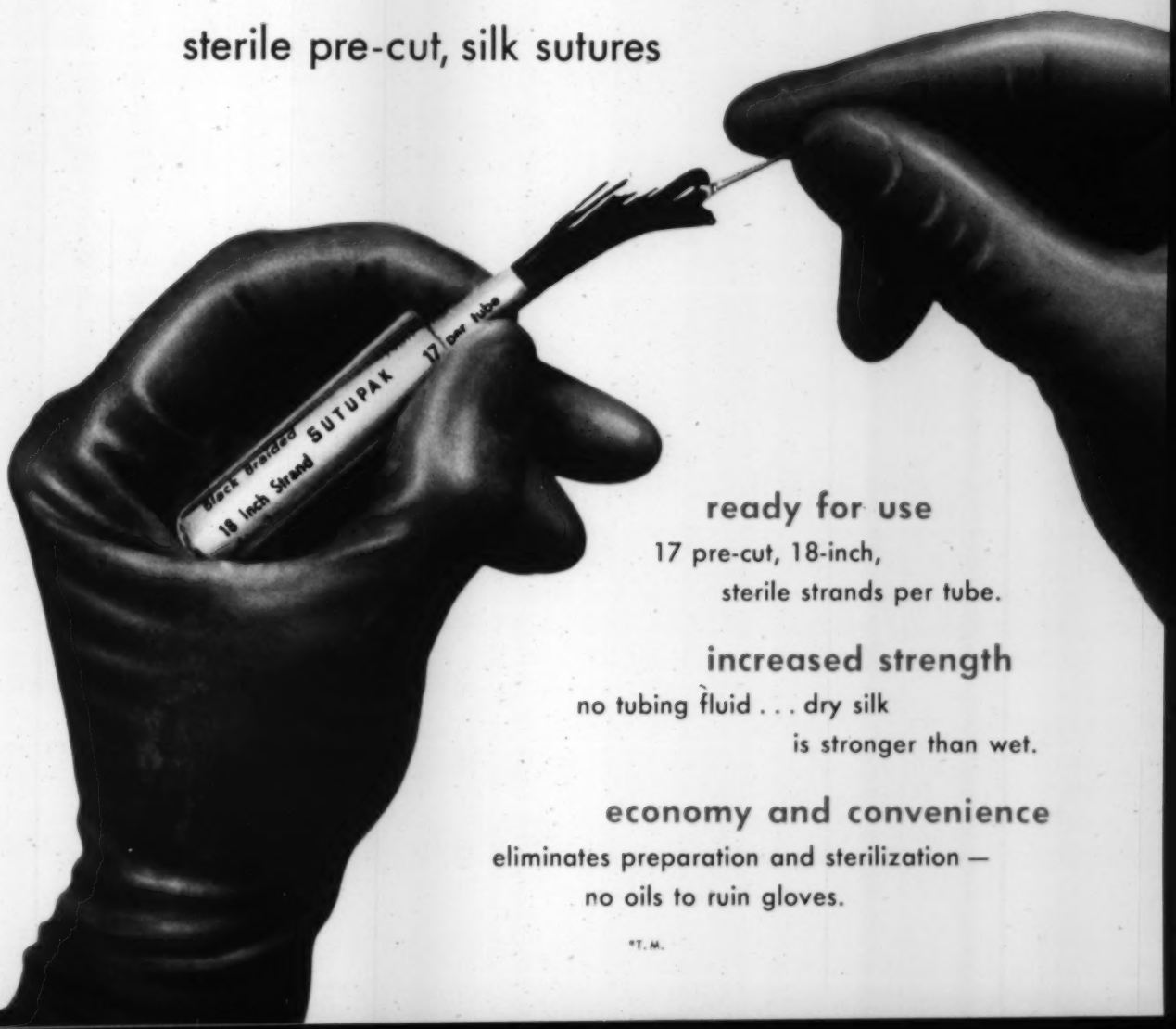

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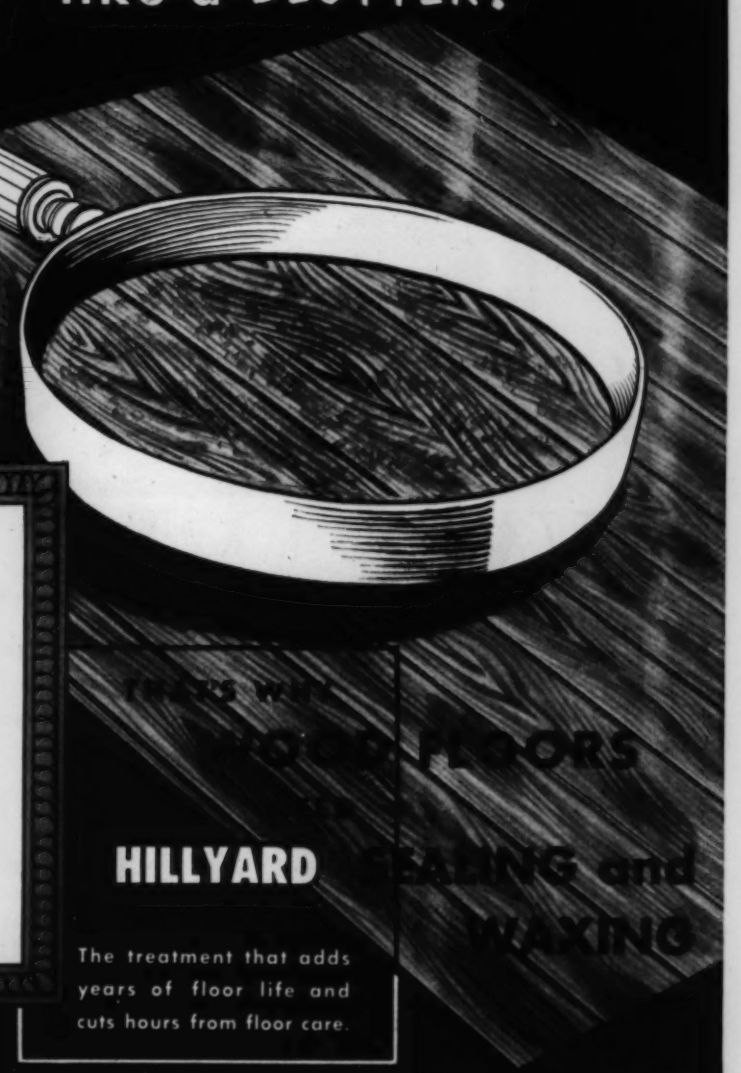

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opinions

ON MAJOR PROBLEMS FACING HOSPITALS—IV

THE FACT THAT a problem may turn up only occasionally in a compilation of the worries that hospital administrators have does not necessarily mean that this problem is not an important one. During 1952, HOSPITALS surveyed the members of the American Hospital Association's House of Delegates and asked them to list what they considered the major problems facing hospitals. A summary of the responses, as published in this department during November, December and January, shows that nursing and finances led the list. But several members of the House of Delegates also listed other problems which did not fall definitely into those categories but which nevertheless constitute important worries to hospital administration. Some of these are summarized below.

Lack of understanding is key problem of administration

I believe the most important single problem facing hospitals at the present time can be summarized in one short phrase—lack of understanding:

—On the part of the public of the basic organization of its local hospital.

—Of the problem of hospital financing.

—Of the problem of shortage of personnel of all types.

—Of the problem of increased demands for service.

—Of the problem of the impact of new ideas and new developments in medical treatment.

—Of the problem of new drugs, their cost, and the demand of the patient that these items be used.

—On the part of the hospital that the patient is an individual, that the patient and family are depressed and anxious.

—Of the problem that the public relations or public understanding must occur at the local level.

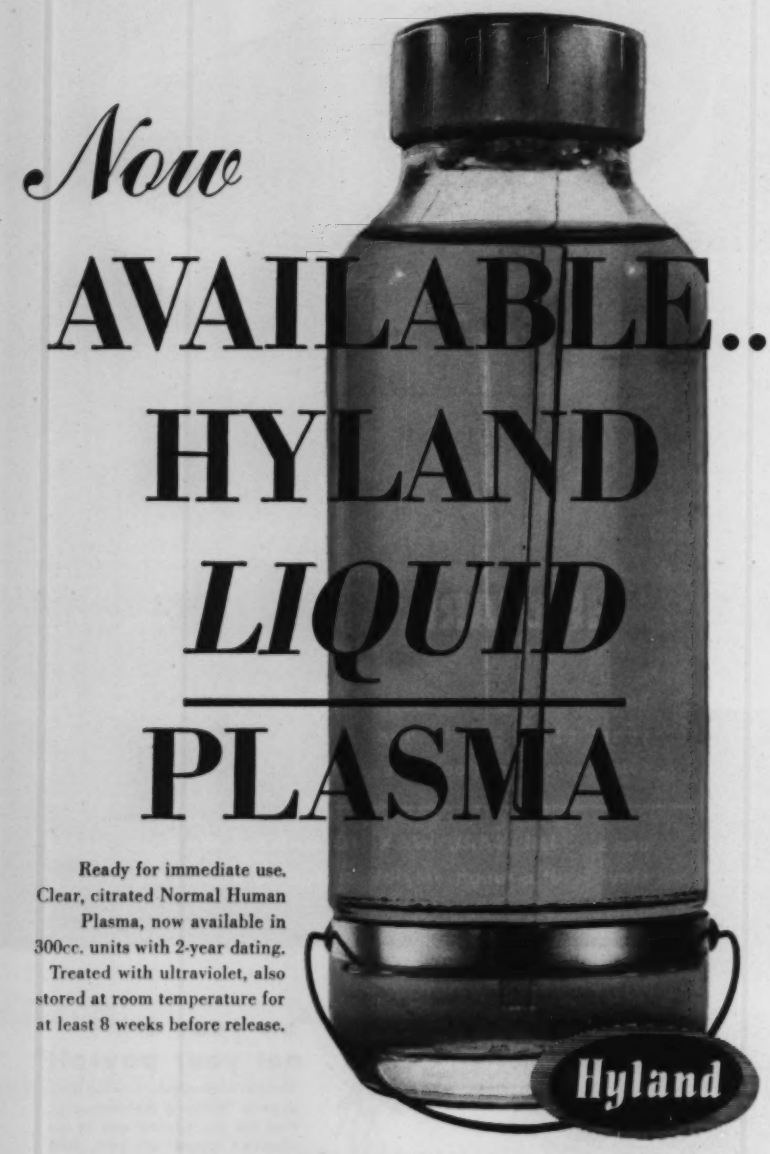
—On the part of the medical practitioners of the problems of the hospital.

—Of the public in that the doctor controls, to a large extent, the hospital charges of his patient.—B. D. DANN, *superintendent, Hackley Hospital, Muskegon, Mich.*

Trustee-doctor-administrator relations need improvement

The most important problem facing hospitals today is, in my opinion, the growing discordant relation of the trustee, physician and administrator. No one will dispute that the relationship today is strained to say the least.

I believe that the threat of government control has made each member of this trio re-evaluate his present position and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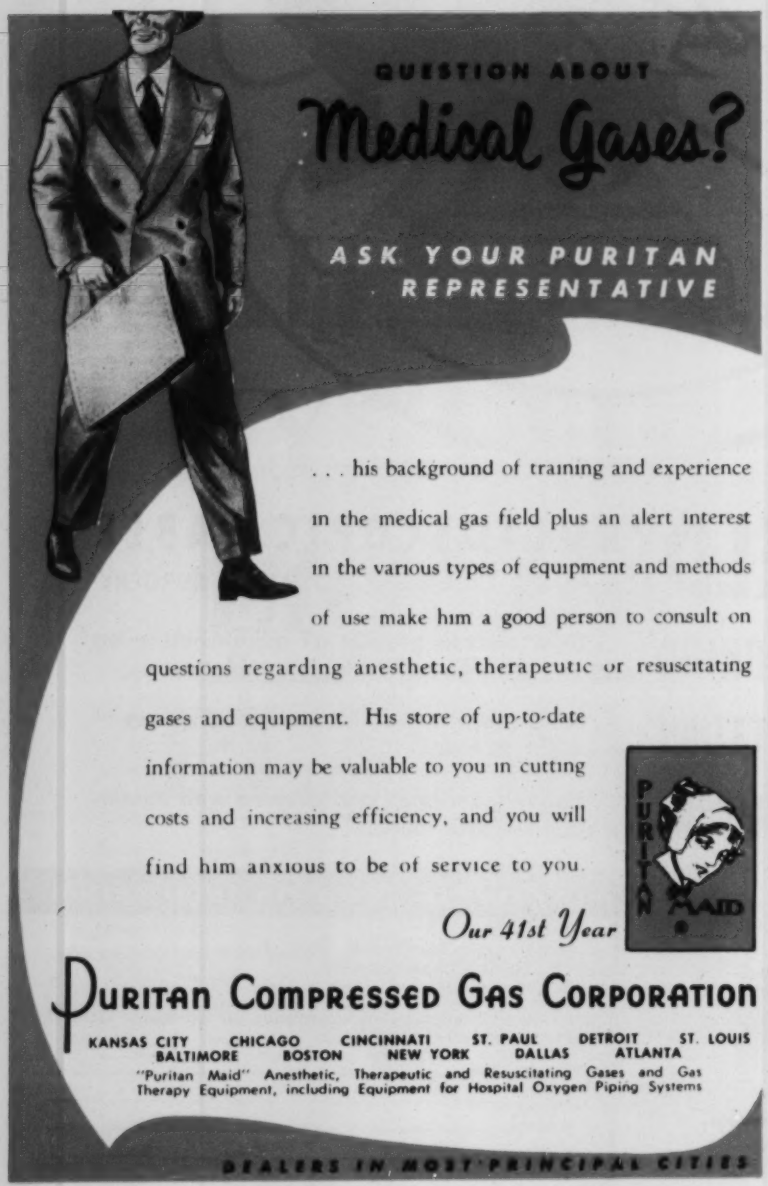
authority in hospital affairs. In an effort to make sure of this position and authority there has been a tendency at times on the part of one or all three to aggressiveness. In some instances they have directed this in areas and departments in which they are not prepared or qualified.

For example, some doctors have become excessively interested in hospital management, certain administrators have tended to dictate to doctors on medical management, and trustees have been known to fail in following the advice of their state medical society in staff matters. It seems to be a sort of a survival conflict with a tendency to assume authority in a frantic effort to find the solution and to blame others for any troubles which may exist. The very existence of hospital and medical practice depends on the three working together.

If we are to have hospital operation and medical care on anything resembling a voluntary basis, I think we must face the problem realistically and prepare to adjust objectively and cooperatively rather than to place blame and to assert new authority.—WINTHROP B. OSGOOD, M.D., *administrator-superintendent, Memorial Hospital, Worcester, Mass.*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Biggest problem of hospital is concerned with people

While financing, fluctuating census and the shortage of nurses are important and trying issues, we believe the bigger one is concerned with people—the personnel, the employees, the staff. It is the task of inducing people to work together toward a common predetermined goal. It deals with supervision or management, both professional (including the doctor) and nonprofessional, at all levels and with varying degrees of responsibility. It includes the synchronizing of the thinking, objectives and activities of the many groups in the organization; to awaken in each the sense of interdependence of one on the other. It is vitally concerned with the relationships among individuals, groups and departments.

For many years the leaders in industry overlooked this human element and their best efforts in all other directions brought only fair results. We should profit by their mistakes and concentrate now on understanding and using these human relationships which apparently comprise the major factors in the success of an endeavor.—A. C. KERLIKOWSKE, M.D., *director, University of Michigan Hospital, Ann Arbor.*

Better management methods are needed in hospitals

It seems to me that the Number One problem in hospitals is the need for improvement in their general management. This problem is being well recognized by the American Hospital Association in its sponsorship of the Commission on Financing of Hospital Care and its proposal for an Institute of Hospital Affairs.

As has been well stated in advocacy of the creation of the commission and the institute, hospitals have fallen far behind improve-

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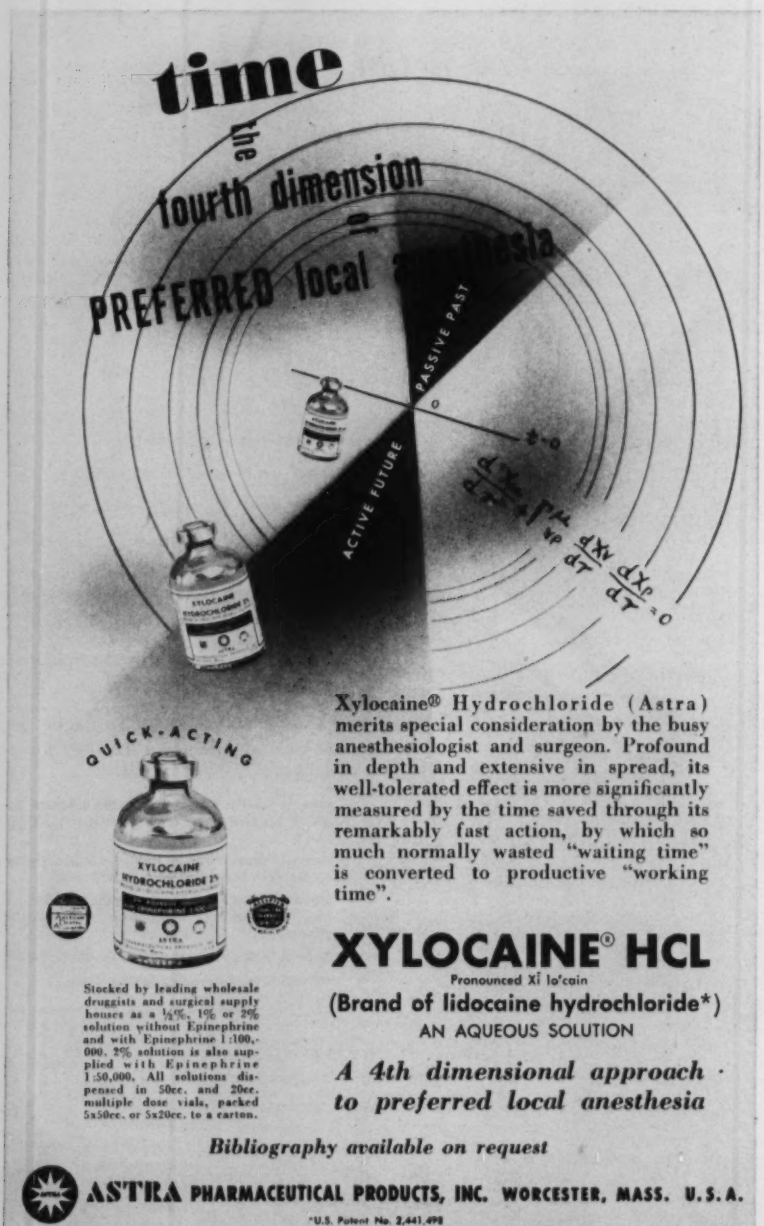
ment in medical practice, technological and architectural developments and in particular have not kept pace with business and industry in the application of scientific management methods to the increasingly complex operation of the hospital.

All of our problems in financing, staffing, public relations, and relationships within the segments of the health field point up the fact that we have been far too slow in using the body of information already existing in other fields and have failed to develop adequate tools through management-research of our own.

From small beginnings which have been made, from facts and patterns which may emerge from the studies of the Commission in Financing of Hospital Care, from the body of existing knowledge in other fields and from a far-reaching program such as that envisioned in the proposal for an Institute of Hospital Affairs, we must develop the managers and the managerial tools necessary to bring hospitals into focus with the problems they face in developing the best care at the lowest possible price.—F. Ross Porter, *superintendent, Duke Hospital, Durham, N. C.*



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*U.S. Patent No. 2,441,498

An understanding medical staff is essential to management

I have come to the realization that the greatest problem is not the cost but the explanation and education of the reasons for the cost to the public but more particularly to the members of our medical staffs.

Recently I had occasion to observe several examples of a growing friction between a minority group of doctors and some hospital administrators. For example, one doctor whose patient was injured in the hospital became very irate when he learned that a report had to be made to the administrator's office. Another physician is an advocate of a policy that there should be no lay members of boards of trustees of hospitals.

More important than these minor irritations is the constant failure of many physicians to understand why hospital costs have risen so rapidly in the past 10 years. As a result of their misunderstanding, many patients are completely overcome when they enter a hospital and are told what the daily room rate will be.

To overcome this apparently widening breach, some of us are fortunate enough to have some outstanding doctors as members of the committees within the hospitals, and in addition to constantly explaining problems to the committees, a few of us are regularly attending medical staff meetings and have been invited to put on a program at least once a year on problems of hospital administration for the benefit of the entire medical staff. Such opportunities should never be overlooked.

The education of the public about problems of hospital administration will best begin at home. There is no better place to start than with the medical staff.—Orville N. Booth, *administrator, Saint Francis Memorial Hospital, San Francisco.*

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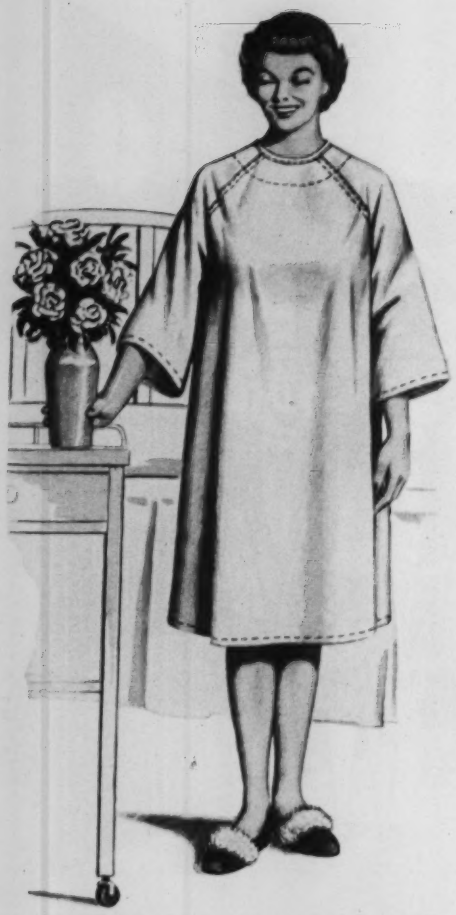

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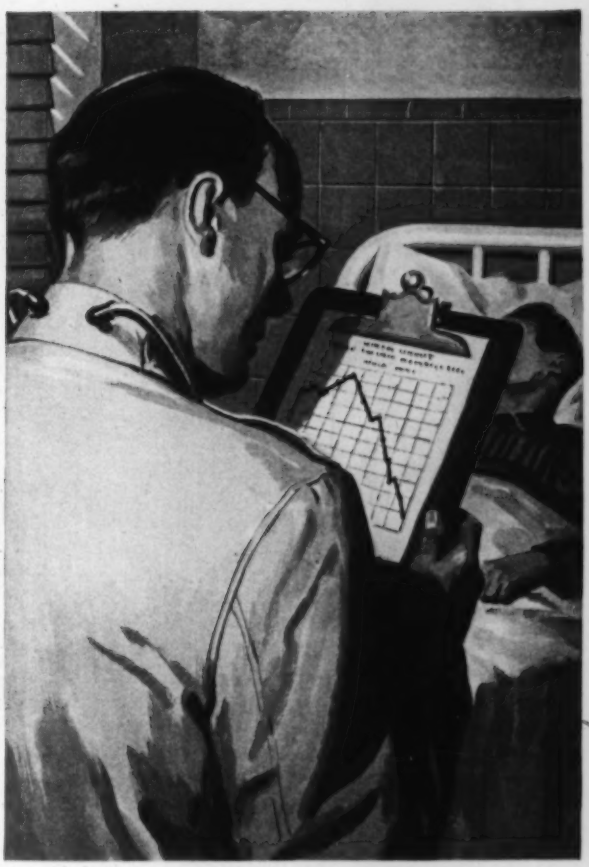

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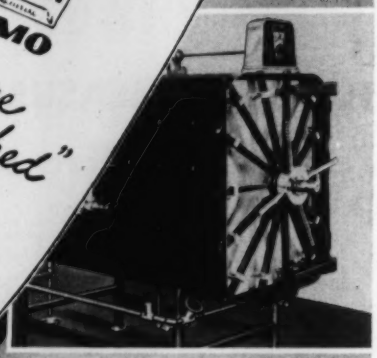
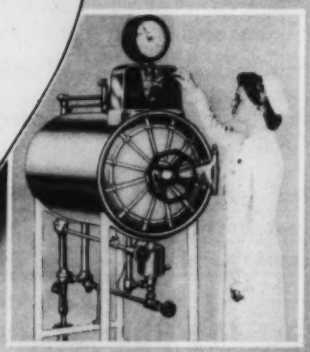


APRIL
MEMO
Announce "All-Welded" Monel Construction for American Sterilizers
1949



MEMO
Announce "Cyclomatic-Control" for American Sterilizers
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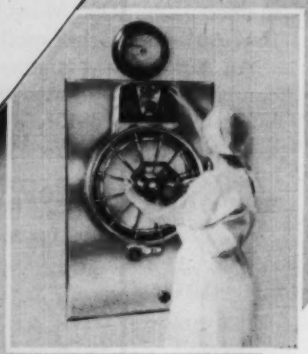

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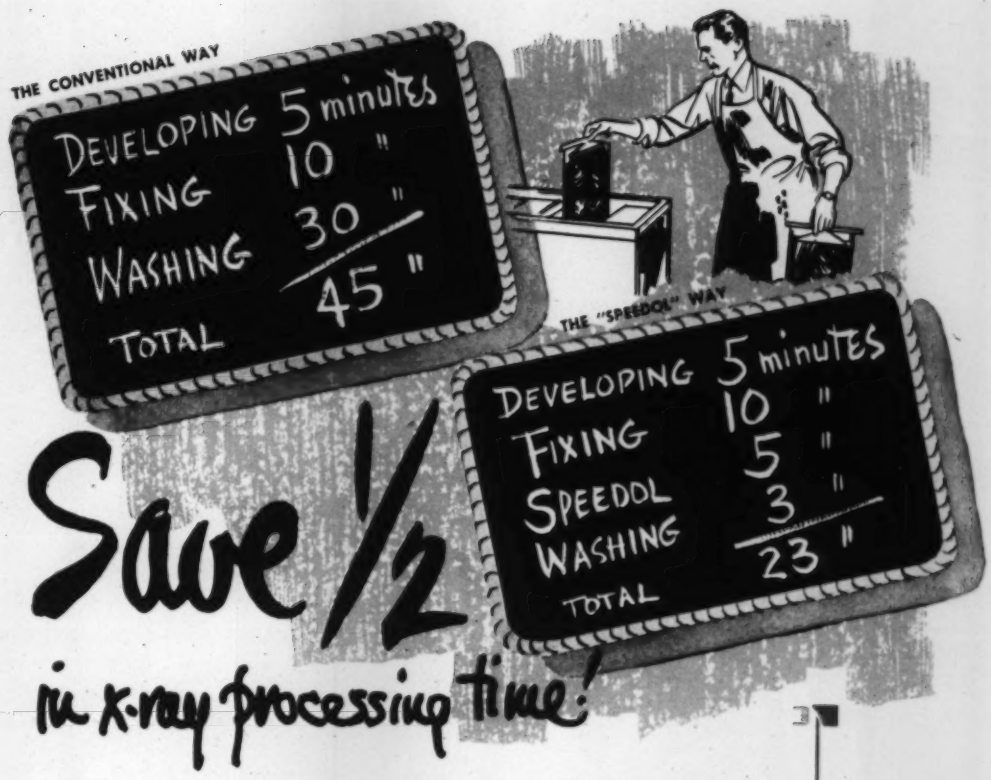

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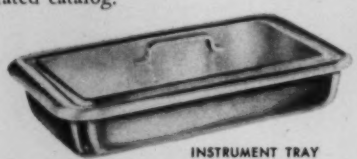

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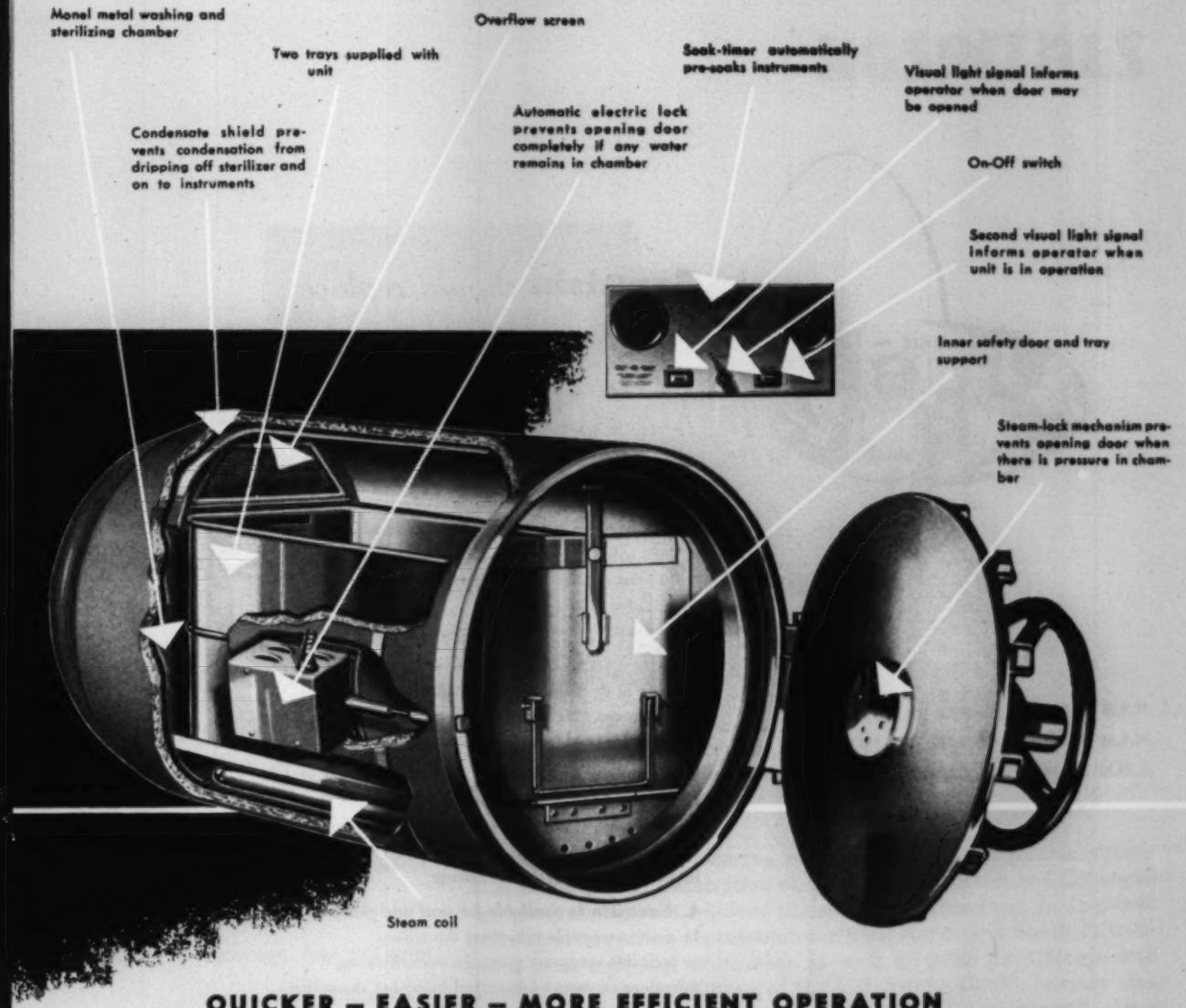
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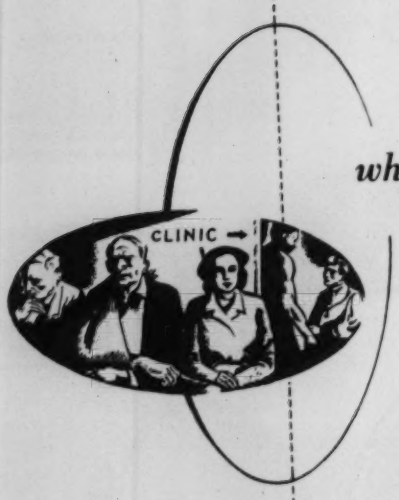

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interstate hospital planning

HELEN L. KNUDSEN, M.D., M.P.H.
ELMER C. SLAGLE, M.P.H.
DONALD R. FREEMAN, M.H.A.

unless adjoining states agree to sensible, interstate planning, they will have the problem of duplicate hospital facilities along their borders. This is how Minnesota, Iowa, Wisconsin and the Dakotas pooled their planning efforts; these are the questions each state must ask of itself and its closest neighbors . . . .

INTERSTATE HOSPITAL PLANNING, particularly by state agencies responsible for the administration of the Hospital Survey and Construction program, has not received the attention it deserves. This became quite apparent when representatives from North and South Dakota, Iowa, Wisconsin and Minnesota as well as from the Chicago and Kansas City Regional Offices of the U.S. Public Health Service met early in 1952 to discuss hospital planning and development along their respective state borders.

A detailed study of existing and proposed hospital location revealed that there are several critical areas along these state borders where there is the possibility that too many beds now exist and others where proposed planning may result in a superabundance of beds. Likewise, in other areas proper consideration has not been given to the natural flow of populations across state lines and the state plans did not provide sufficient beds to meet the needs.

Contrary to popular opinion about the needs for small hospitals in small communities, there is a definite trend in Minnesota for people to seek medical care and hospitalization in the larger communities where there are modern and more complete facilities. This, no doubt, is also closely related to the development of medical groups whose individual members have received training in the more common medical specialties. It is quite possible that in the future certain areas may actually show a decreased usage of the small rural hospitals and at the same time an overcrowding of the larger hospitals in the same area. Experience has clearly demonstrated that communities in which

The authors of this article are officials of the Minnesota Department of Health, Minneapolis. Dr. Knudsen is chief of the Section of Hospital Services; Mr. Slagle is a public health engineer for the same section; Mr. Freeman is an analyst of hospital services there.

there formerly resided one or two outstanding medical practitioners whose reputations attracted patients from considerable distances, and where hospital facilities were developed as a result of the demands can expect to see a decrease in hospital utilization when these physicians retire from practice and when adequate facilities and services are developed in other nearby areas. There is also a definite trend on the part of communities to assume the responsibility of providing hospital facilities which were formerly developed and provided by physicians. In several instances such a town may no longer represent an ideal location for a hospital. This is particularly true where adjacent communities have provided larger, modern hospitals.

COMMUNITY PLANNING

Once the residents of a community have become accustomed to a local hospital service it is exceedingly difficult to convince them that a larger, more adequately equipped and staffed hospital a few miles distant would serve them better. On the other hand, as the enthusiasm for a new hospital develops in a small community where a hospital has never existed, it may be possible through education and persuasion to impress the sponsors that their location cannot provide and support the best in hospital facilities. Rarely is it possible to convince such communities that their needs will be served best by pooling their resources with an adjacent, larger town. In two instances in Minnesota, however, communities have provided clinics with diagnostic facilities which have served to attract physicians. These communities have later expressed satisfaction in their medical service and in the adequate hospital service provided in a new hospital in a nearby community.

The natural tendency in developing a state plan for hospital services is to provide sufficient beds to accommodate the residents of the state. It is also natural to carry this planning to the periphery of the state, making a sharp break at that point without giving proper thought to nearby existing or proposed facilities in the adjoining state. Thus, overbuilding rather than underbuilding is more likely to occur along state borders. This can become extremely critical and result in unnecessary duplication of facilities and personnel, low occupancy rates and higher costs of hospital care. In some instances this overbuilding has been accentuated by communities having constructed hospitals entirely with their own funds in locations which were not proposed in the state plans and at a time when the state agencies were not completely aware of the value of a sound educational program. This is an extremely critical problem.

If such communities cannot be persuaded that their planning is unrealistic and uneconomical there is no alternative except to provide the usual advice and assistance in planning in order to insure that good minimum standards will be incorporated. No official agency is in a position (nor should it desire the authority) to assume a dictatorial position in such a major decision. As the only alternative, it becomes mandatory that the state agency reduce the number of beds proposed at one or more nearby designated locations, or in a few cases, that certain proposed hospital locations be eliminated from the state plans.

CONVERTED UNITS

In areas which already are overbuilt, it appears that one possible use for such buildings is that of conversion to nursing homes and homes for the aged, the needs for which are growing rapidly as our problems in the care of the aged and chronically ill continue to increase. Buildings designed as hospitals, however, do not lend themselves too well to the care of this type of patient since spaces for day rooms and dining areas, corridor widths, accommodations for wheelchairs and the like have not been given proper emphasis. Furthermore, it is an expensive type of construction for such conversion. A well-planned home for the aged or a nursing home might be constructed for approximately one-third to one-half of the cost of a hospital of comparable capacity and would be much more functional from the standpoint of the patient.

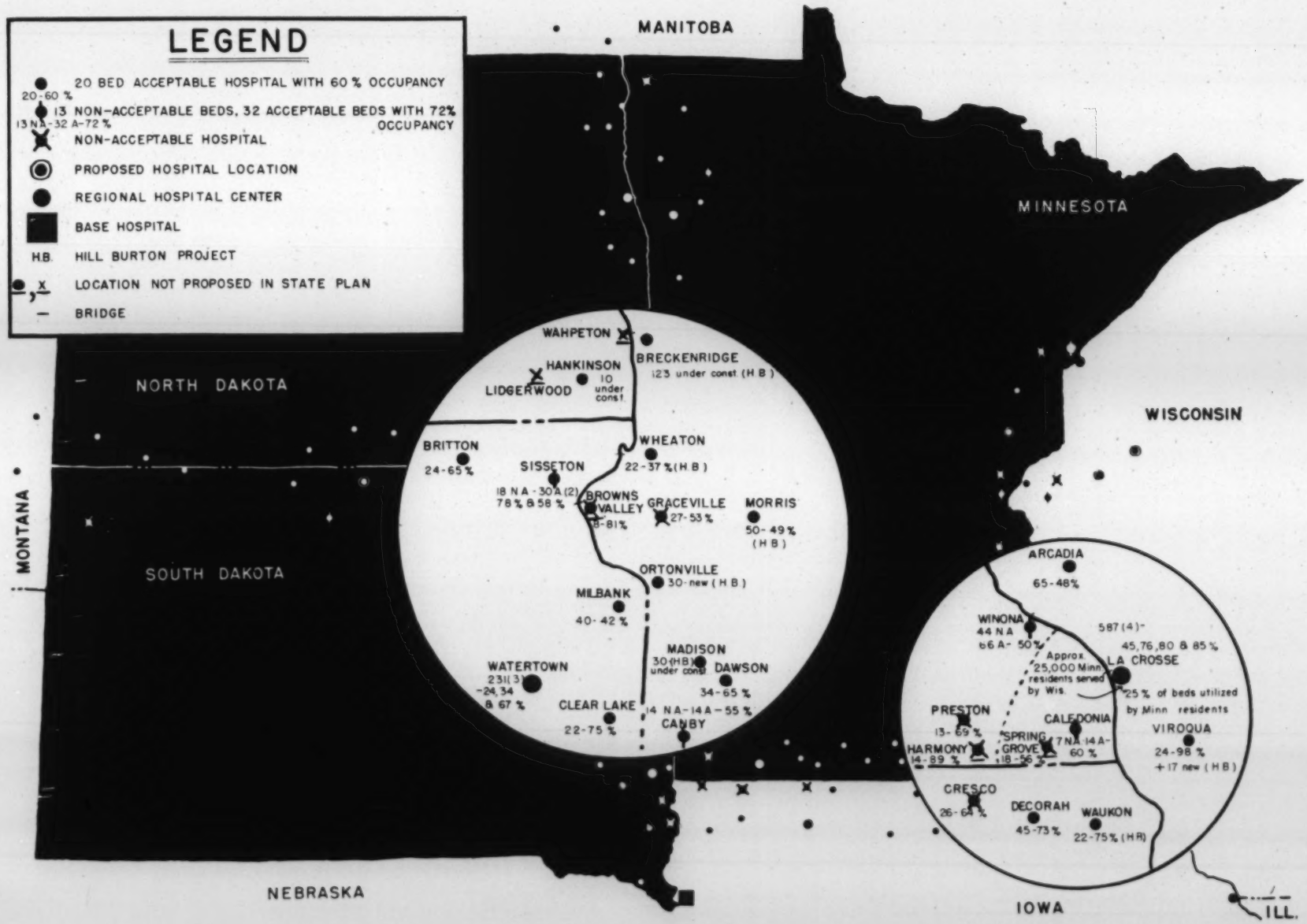
INTERSTATE PATIENTS

The value of the study of the number of patients admitted from an adjoining state to the larger border hospitals became increasingly apparent as the study progressed. It has been determined that approximately 5,000 residents in the southwestern corner of Minnesota are presently served by the Sioux Falls, South Dakota, hospitals; that about 3,000 people in the northwestern corner of Iowa are similarly served; that Sioux City, Iowa, is caring for the hospital needs of 7,000 people in the southeastern section of South Dakota and that 25 per cent of approximately 117 of the beds in the four hospitals in La Crosse, Wisconsin, are utilized by Minnesota residents. A large number of Wisconsin residents come to the hospitals in Minneapolis and St. Paul for the more specialized types of care and it would be exceedingly valuable to obtain more detailed information on the out-of-state patient admissions to these hospitals.

A summary of pertinent data was prepared several weeks in advance of the conferences and sent to each of the states concerned. This information included a list of all border areas with their contained populations, the names of the towns within each area with existing or proposed hospitals, the type of hospital ownership, the number of acceptable and non-acceptable beds in each hospital, data relative to occupancy rates, physicians' services, plans for new construction or additions, extent of local activity, hospital planning not included as part of the state plan and other details peculiar to the individual area. It was suggested that comparable information be prepared by each state prior to the meeting.

Large maps showing the Minnesota border areas and hospital locations as well as contiguous areas

This large map (parts of which are spotlighted here) shows Minnesota border areas and hospital locations as well as contiguous areas in adjoining states.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in the adjoining states were prepared for use at the meeting. Highway maps were also secured for each of the states involved. It was found that detailed information for each hospital showing the trend in the number of patients admitted, patient days and occupancy rates for the last five years was very helpful in discussing the current and future needs of the individual hospitals. It is important that such data be kept current.

Considerable time was spent in a general discussion of the data prepared by each of the states as described above. It was decided that the best results would be obtained by a detailed discussion of each border town, hospital location and hospital area by each of the states involved. Details relating to hospital and medical services, geographical barriers such as rivers and lakes, means of transportation including highways and bridges and the natural flow of individuals to trade areas were also covered.

Representatives from North and South Dakota discussed their common problems at the same time that Minnesota and Iowa worked together; then South Dakota, Iowa and Minnesota discussed the factors involving those three states and so on. A map was prepared showing the more pertinent details and conclusions. These were supplied in quantity to the states concerned for distribution to their state advisory councils and other interested individuals.

PROBLEMS DISCUSSED

Some of the typical problems and situations discussed can be summarized as follows:

1. The occupancy of a 28-bed hospital has decreased from 100 per cent to 57 per cent in five years. One hospital across the state border recently has been completed and a second is under construction. The community has been advised to postpone plans for remodeling and building an addition until sufficient operating experience relative to the new hospitals has been obtained.

2. A 42-bed, non-acceptable facility has shown consistently high occupancy rates for five years. The community is interested in replacing the old hospital but is contemplating 100-125 beds whereas the state plan designates only 80 beds. The provision of more than 80 beds does not appear realistic since a larger city with two acceptable regional hospitals having a total of 339 beds and plans for considerable expansion, with 11 times as many physicians, many of whom are specialists, is located immediately across the river. It is obvious that the larger city is serving as the regional hospital center for a portion of both states. This area requires continued study.

3. Two towns immediately adjacent to one another across state borders were being served by two small non-acceptable hospitals operated by the same order of sisters. A single large hospital has recently been opened which will serve a fairly large section of the population of both states. Both of the old hospitals have been or are being converted to nursing homes. These two communities will be considered as a single hospital location in both state plans.

4. The occupancy of a new regional hospital is increasing very slowly because of three new, small hospitals constructed in the same state but not as part of the state plan during the period the regional hospital was under construction. As a result, the number of beds proposed at two or three of the hospital locations across the state border have been reduced in the revised state plan.

5. Enthusiasm for a new hospital has developed in three locations in one area, with none of the three towns adequate in size to support a good facility. A larger town in the adjoining state could serve part of this population and the necessary adjustments have been made in the two state plans.

6. Where large cities with good facilities and specialized personnel are located along one state border, it might be well to extend the regional boundary across state lines to present the picture as it actually exists.

7. In a number of cases, the old, non-fire-resistive hospitals which are being replaced with new installations are being converted to nursing homes and homes for the aged. The installation of sprinkler systems in such temporary buildings will insure adequate fire protection. It is obvious that the provision of nursing home care should be considered in interstate planning in the near future. Further study is needed on how such sprinklered buildings should be classified in the state plans as to acceptability.

8. The provision of hospital care for Indians living along state borders and elsewhere in the state must be considered in future planning since it is quite apparent that community hospitals will absorb the hospital care of Indians residing in the respective hospital areas. It was also agreed that more information is needed relative to patient service data in veterans' hospitals and their impact on future planning.

In conclusion, it would seem that the following may be said with respect to the first known attempts at interstate hospital planning conferences:

1. The information obtained and the discussions which developed are extremely valuable from the standpoint of over-all state hospital planning.

2. More data should be obtained on patients admitted from out-of-state to hospitals along state borders, particularly in the case of the larger hospitals.

3. Interstate hospital planning should be a continuing process with joint meetings held every year or at least every other year.

4. State planning agencies should act as individual clearing houses for pertinent data relating to hospitals along their borders, making this information available to adjoining states and to interested individual and groups.

5. It is highly important that copies of each revision of the state plan be made available to all border states which should have a special interest in interstate planning. Copies of summaries of state plans should be made available to all states.

6. Data relative to interstate hospital planning should be incorporated in the annual state plan revision developed by each of the states.

For medical records—

MODERN FILING SYSTEM

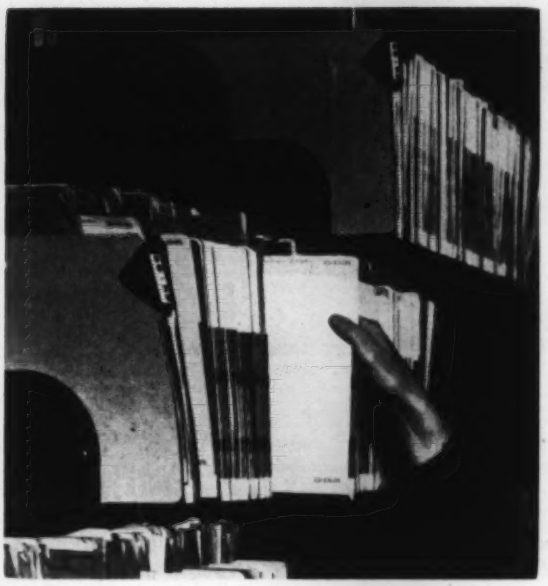
cuts

√ TIME

√ SPACE

√ COST

√ ERROR



ALICE BEAULIER, R.R.L.

THE MASSACHUSETTS MEMORIAL HOSPITAL, Boston, a teaching hospital associated with the Boston University Medical School, decided to reorganize its medical record department to keep pace with its expansion.

The chief record librarian in charge of reorganization wanted to install a new system as inexpensively as possible and to reduce operating costs.

A survey showed that the cost per inch of filing in a grade A filing cabinet was 95 cents, while the cost per inch of shelf filing was about 35 cents. In most instances it is possible to file from 50 to 75 per cent more folders on shelves than in regular filing cabinets, using the same amount of floor space. These facts, plus the ease of moving through the aisles, led to our adoption of open shelving and the terminal digit system.

As soon as the shelves were up, 100 evenly divided spaces were marked off, and the guide cards placed from 00 to 99. We have only the first guide card, no others are needed. The case histories were taken from the files, sorted according to the last two digits and placed on the shelves. Two file clerks, with a sorter on a typewriter table sorted the records according to the second and third digits. This sorter is a light, steel bar divider from 00 to 99.

The complete installation of shelving, new folders and terminal digit filing was completed in two months, with only one extra full-time employee, and several hours of overtime work.

The highest grade folder is the most economical because there are practically no replacements due to wear and tear. We chose a folder made from a highly refined vegetable fiber, which is also surface-sized to increase life, reduce soiling and permit pen and ink posting.

Perhaps the most common cause of misfiling folders is the transposition of numbers. By tinting the folders on the right-hand edge of the inside flap, using two different colors, orange and green, and using a series of one-half inch black squares in this tinted space, transpositions are easily and quickly obvious. For example, if the terminal digit number 87 is filed in the 78 section, it is immediately detected because the tinting on the 78 section folder is a different color from the 87 section folder. If the black squares do not line up with the black squares in the rest of the section, it is easy to see that the folder has been misfiled.

We have not found dust to be a particular problem. In fact the records on the open shelves are easily accessible to vacuum.

Our hospital is one of the first in the country to install this color-control system and in our brief experience the perennial headaches of misfiling folders are now a thing of the past.

We were able to consolidate two record rooms and have room for a 10 year expansion. We have also found that fewer personnel are required in the record room, and we have a smoother functioning record department.

Mrs. Beaulier is chief medical record librarian, Massachusetts Memorial Hospitals, Boston.

moved to our new building . .

ROBERT G. BOYD, F.A.C.H.A.

A NUMBER of major problems had to be solved in the process of moving from the old Morristown (N. J.) Memorial Hospital to the new building two miles away:

1. The exact date that the hospital could take over the building could be ascertained only a few days in advance.

2. Much equipment in the old hospital had to be repaired and repainted.

3. The entire move had to be by motor vehicles because of the distance involved (about 1.8 miles).

4. A staff had to be built up for a hospital twice the size (236 beds) of the old one (122 beds).

5. Plans had to be made for the maintenance of the old hospital (10 acres and 11 buildings) pending its sale.

6. Rules and rates had to be revised and new rules and rates established in many instances.

7. We had to start admitting patients to the new hospital as soon as possible to start getting patient income to offset the operating expenses. (We took over the building on June 2, 1952 and started receiving patients there on July 26.)

The technique used for "pulling things together" was a series of meetings. Beginning about a year before the move, numerous informal discussions were held. About 90 days before the move, two meetings were scheduled with department heads to discuss the problems based on notes taken in the informal discussions. In these departmental meetings it was emphasized that each department head would be responsible for the moving of his department and he was told with whom he was to work in the detailed planning. Finally, a separate get-together was held with each department head and the persons responsible for providing the physical facilities and personnel.

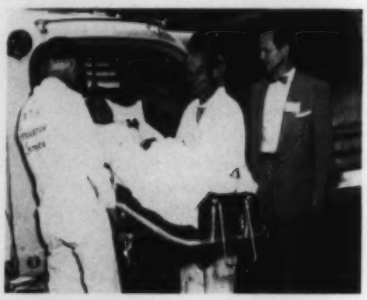
In the second departmental meeting, the hospital director designated the persons in charge of the several areas of responsibility in providing the physical facilities and personnel for the move. He followed this with a confirming memorandum issued on the day following the meeting.

The assistant director was assigned to the purchase of new equipment and supplies and the selection of equipment to be transferred to the new hospital. The areas of responsibility for the chief of maintenance included all mechanical installations, carpentry, electrical work and painting; the moving of equipment and supplies by our own men (other than those in the department to be moved); and the watchmen at both hospitals.

Another assistant took charge of the moving by commercial movers. Personnel authorized for the new hospital and the dates when such personnel had to be obtained fell under the jurisdiction of the personnel assistant. The director of nursing service, with the advice of the medical advisory committee, had the responsibility for the transfer of patients. Volunteer workers came under the province of the volunteers assistant.

The volunteers assistant and the administrative intern also were placed in charge for the opening ceremony of the new hospital. A committee of nurses and a committee of the board of trustees (who supplied station wagons and manpower) were given the re-

FIRST patient to leave the old hospital is placed in one of the volunteer ambulances.



Mr. Boyd is director of the Morristown (N. J.) Memorial Hospital.

..2 miles away

sponsibility of moving nursing personnel and their personal effects. This move, dubbed "Operation Station Wagon," was from the nurses' residence at the old hospital to the new residence at the new hospital.

In the aforementioned memorandum, the director kept for himself the final timing of each individual move and its coordination.

As the exact date for taking possession of the new hospital was not known during most of the planning period, the date for receiving the first patient in the new hospital was designated "O-Day" (opening day), and the dates for the various phases before or after the move were shown as 0-minus or 0-plus. For example, it was decided months in advance that the moving of patients would be on a Saturday (in order to make maximum use of volunteers), that the opening ceremony would be on the preceding Saturday (0-7), and that the open house would follow the ceremony and continue the next day (0-6).

PATIENT arrives at the new hospital and is greeted by the president of the hospital.

The opening ceremony and open house were worked out in considerable detail with a special committee composed of the president and vice-president of the hospital and the president of the Woman's auxiliary. A memorandum was then issued and widely distributed.

In an operation of this kind, totally new to all personnel, special and continuing attention must be given to communications. We used the following media:

- Each person attending, *or in any way concerned with each meeting*, was issued a copy of a memorandum summarizing what had been agreed at the meeting.
- Frequent notices were posted on bulletin boards.
- Matters of interest to, and requiring the cooperation of, the general public were covered in the newspapers and through the local radio station.
- Copies of the floor layout of the new hospital were distributed to all employees, and all volunteers concerned with the move.
- The dial telephone system in the new hospital was put into operation as soon as we took over the building, and a temporary "tie-line" was installed between the old and new hospitals.
- Every one of the 18 ambulances moving the patients was radio-equipped and in constant communication with all the others through the radio in the hospital's ambulance, parked at the rear of the old hospital.

Almost a year in advance of the move, data were published showing "capacity," and estimated "peak census" and "average census," floor by floor, in the new hospital. These were used in the planning of personnel, equipment and supplies and in the preparation of the budget. The memorandum setting forth these figures was probably the document that was most basic in planning for the move.

Also well in advance of the move, a joint committee of trustees and doctors was formed to recommend changes in rules and rates and suggest new rules and rates that would be needed in the new hospital. These recommendations were submitted over a six-months' period at the monthly meetings of the medical staff and governing body. As a result, a revised set of new rules and rates was ready about a month before the move, and the new patients' pamphlet was available from the day the new hospital opened for service.

Special provisions were made for our own people to inspect the new hospital. Trustees, doctors, and other special friends of the hospital were sent a letter inviting them to inspect the hospital and asking them to use the letter as a pass. In the same letter we pointed out the necessity for controlling visitors to permit personnel inside the hospital to concentrate on getting the institution ready, and suggested that the visitor take advantage of guided tours during specified periods Saturday afternoons and Sundays. In addition, an open house for employees and volunteers was held on a weekend before the opening ceremony and general open house.

As previously mentioned, a medical advisory committee was formed to assist in planning the moving of the patients. This com-

mittee was composed of an internist, a general surgeon, and an obstetrician plus the senior physicians on the various services at the time of the move. Responsibilities in connection with the moving of the patients were set forth as follows:

1. Necessary orders covering moving of each patient: *Physician in charge.* (A special form, in duplicate, was filled in for each patient. The original was attached to the patient's chart and the duplicate was retained by the chief admitting officer. See illustration.)

2. General professional advice concerning moving of patients: *Medical advisory committee.*

3. Transportation of the patients: *Volunteer first aid squads.*

4. Controlling traffic on grounds of both hospitals and assisting first aid squads and nurses at both hospitals: *Morristown Memorial Hospital corpsmen.*

5. Over-all supervision in moving of patients: *Director of nursing service.*

6. Preparation of special forms with specific orders covering moving of each patient and notifications concerning NO VISITORS to old hospital on day of the move: *Chief admitting officer.*

The selection of the route and the plans for controlling the traffic along the route were worked out well in advance with the local police department. One extremely important detail was the cautioning of all drivers of participating vehicles that the speed had to be not more than 20 miles per hour.

There were certain details having to do with the moving of the patients that are of particular interest. Except for relatives of critically ill patients, no visitors were permitted in the old hospital on the day of the move and no visitors were permitted in the new hospital until after 2 P.M. Identification badges were issued to all employees and volunteers participating in the move. Admissions to the old hospital were stopped at 7 A.M., at which time emergency admissions were accepted in the new hospital. The last meal in the old hospital was breakfast and the first meal in the new one was lunch.

"Emergencies only" were admitted to the old hospital beginning about 10 days before the move. As a result, the census dropped to 63 from an average of about 90. It was possible to move all the patients in the old hospital on the day of the move. The 63 patients moved included: 3 critically ill, 10 ambulatory (who, nevertheless, were moved by ambulance), 11 newborn, 3 from the contagion unit and 36 other adult and pediatric patients. The contagion unit patients were moved in a special ambulance owned by the hospital and operated by specially trained hospital employees. The more seriously ill patients were transferred last. Each newborn baby accompanied his mother. The moving of the patients was started at 9 A.M. and completed by 11 A.M., two hours ahead of schedule although great care and deliberation were exercised throughout the move.

Taking advantage of the hindsight that we now have, we can honestly say that we would not have made any major change in our plans. Of course, we would have changed certain details. Had we known, for example, that two hours instead of double that time was all that was required to transfer the patients, we would have speeded up lunch time; however our dietary department was notified that we were ahead of schedule and, through a magnificent effort, had lunch ready for the volunteer ambulance drivers and our own volunteer corpsmen only about half an hour after the move was completed.

Responsibilities were spelled out clearly and then specifically delegated. The response from our medical staff, employees, and hundreds of volunteers from all walks of life was effective, unqualified and most gratifying.

A SPECIAL form, in duplicate, was filled in for each patient. The original was attached to the patient's chart and the duplicate was retained by the chief admitting officer.

THE MORRISTOWN MEMORIAL HOSPITAL
Morristown, New Jersey

(NOTE: To be placed on outside of chart holder of every patient to be transferred)

PATIENT'S TRANSFER SHEET.

NOTE: To be prepared in duplicate. Original attached to patient's chart, and copy to Admitting Officer.

Patient's Name:

Room No. in Old Hospital:

Room and Bed Nos. in New Hospital:

Is a Physician to accompany the Patient?

(A PHYSICIAN OR NURSE IS TO ACCOMPANY EVERY PATIENT)

Special Instructions:

(Date) (Signature of Responsible Physician)

- Condition of Patient on Arrival -

"Yes" or "No"

Was the condition of the patient the same on arrival as upon his departure from the old hospital?

Did anything occur during the transfer that had an adverse effect on the patient?

If so, please describe what occurred and what remedial action, if any, was taken.

(Date) (Signature of Physician or Nurse accompanying patient)

THE NURSING SERVICE reorganizes

SISTER FLORENCE, R.N.

CHARITY HOSPITAL in New Orleans, a state-controlled institution and one of the largest hospitals in the United States, is maintained for the indigent sick of Louisiana. This hospital, with a bed capacity of 2,970, provides facilities for patients with all types of afflictions. Among the 3,000 employees, 1,300 persons—professional, nonprofessional, and clerical—are engaged in the Nursing Service Department.

While it has always been the object of the Nursing Service Department to give a high quality of nursing care to patients and to meet their physical, psychological, spiritual, and social needs, certain situations brought about by changes in techniques, procedures, physical facilities and personnel have resulted in an increasingly complex situation. This development made it necessary, recently, to evaluate the organizational structure and each major element of the department, to determine whether the pattern was consistent with and conducive to the accomplishment of the department's objectives. Representatives from Columbia University, New York City, were invited to participate in the project, and the Nursing Service Department underwent minute investigation. In the final report, an additional number of assistants with definite and delegated functions was recommended.

The organization and administration of the department were analyzed for evidences of outmoded and outdated regimes. In studying the structural plan of operation, the initial purpose of the hospital was kept in mind. This helped to determine whether the proposed change would be conducive to better and more efficient care of patients. It seemed probable that any plan which would provide a wider base for exercising responsibility, involving a "partnership" type of leadership, would be preferable to a system which provided only two or three individuals on the administrative level. Formerly, leadership was conceived to be something of a "solo" nature. Trails were blazed by fearless, indomitable characters exercising all of their individual powers in the performance of their activities. But today, the ever-increasingly popular approach on a cooperative, organizational, and group basis seems to have taken precedence. It was emphasized that every necessary function involved in the purpose and objectives of the organization should be assigned to a unit of that organization, that the responsibilities assigned to the units be specifically understood, that no function be assigned to more than one independent unit and that consistent methods of organizational structure be applied at each level of the organization.

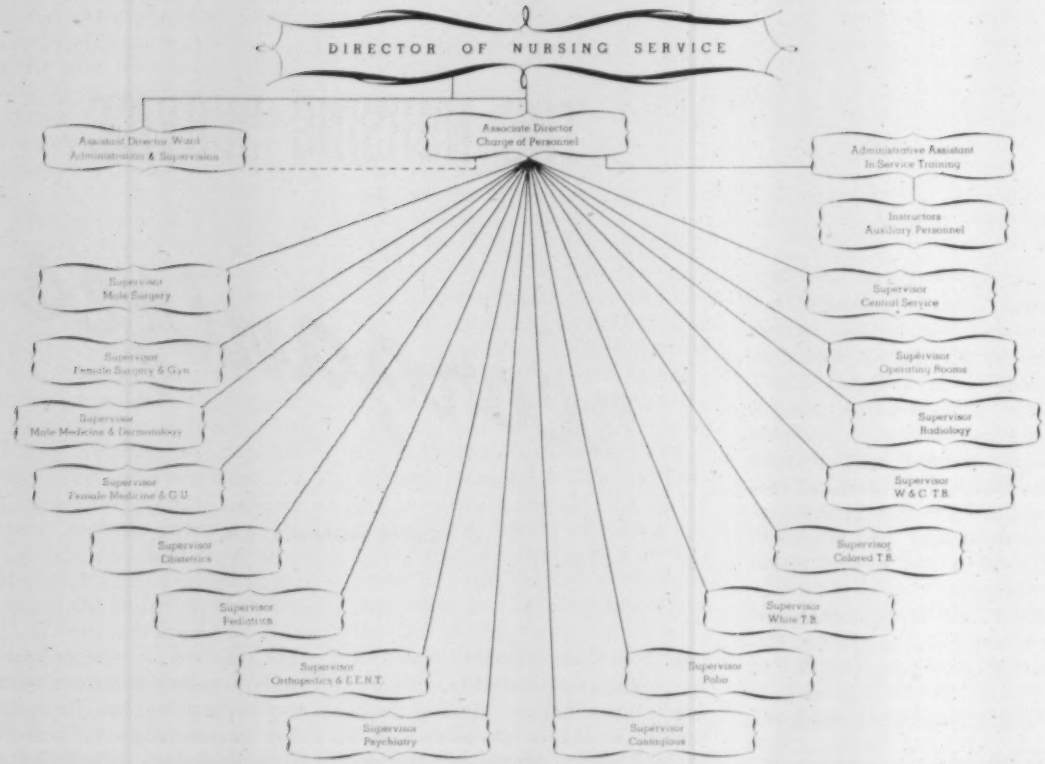
Care was taken that in the plan, each member concerned would understand to whom she would be responsible, and that those under supervision would know to whom to report, also, that no member would be responsible to more than one person. Since responsibility for a function is matched by the authority necessary to perform that function, it was necessary to study whether sufficient authority was being delegated. The authority and responsibility for action was to be delegated to individuals responsible for the actual performance of duties so long as such decentralization would not hamper the necessary control over policy or the standardization of procedures.

It was realized that principles for the Nursing Service Department were no different, basically, from principles of administration for other types of organizations. It was noted that human relations in the administration of nursing services were typical of those noted wherever there were various levels of workers, involving few or many people.

In the reorganization process, two additional principles of administration were considered: First, that representation from all divisions of the Nursing Service Department, at the level where ultimate authority and responsibility was vested, would be desirable; second, that explicit group representation in deliberations upon policies affecting that group would be essential.

Departmental supervisors had been talked about and recommended before, but the idea seemed rather remote and impractical. Not until the plan was con-

Sister Florence is director of the Nursing Service, Charity Hospital, New Orleans.



THE OLD ORGANIZATION

sidered in conjunction with and as a part of the Nursing Service Administrative Division proper did it look feasible. It was with this connotation in mind that the new organizational structure took shape.

One of the first questions which arose in the minds of various individuals was, "Where does this new structure place us administratively?" If the plan may be considered as it pertains to function rather than to personalities, possibly it can be visualized more easily and accepted with less apprehension.

It has been said that "There is nothing new except what is forgotten." In reviewing the organizational charts, evidence was found that undoubtedly one principle of good administration had been overlooked: "Not all the managing should be done by the management." Delegation of authority and provision for sharing of responsibility needed to be shown. It was realized that no sharp line could be drawn between planning and executing, nor could one group be expected to do all the planning and another group all the executing. A system providing for assistants to the director of nursing service, representing each of the clinical divisions which comprise the Nursing Service Department, was therefore established.

Accepting the recommendation that no administrative head should have an excessive number of individuals directly responsible to him or reporting directly to him, and that organizational structures should expand horizontally as well as vertically, a structure was set up which provided for eight assistant directors, one administrative assistant, and one instructor for inservice education. It was obvious that this number of individuals, with the director, could have continuous, effective, and daily contacts. This plan did not suggest the elimination of personal contacts of other individuals in the nursing service divisions with the department head.

In conformity with these recommendations, it was decided that with the director of nursing service, the following assistants would comprise the administrative group: (1) Assistant director—in charge of professional and nonprofessional staff education; (2) instructor—inservice program for auxiliary personnel; (3) assistant director—surgical services; (4) assistant director — pediatrics service; (5) assistant director — neuropsychiatric service; (6) assistant director —central service department and operating rooms; (7) assistant director — obstetric service; (8) assistant director—communicable services, including poliomyelitis, and tuberculosis divisions; (9) assistant director—medical services (yet to be appointed); (10) administrative assistant in charge of the nursing personnel employment division.

Prior to the placement of the assistant directors in an administrative capacity, all were assigned to their respective services for a period of time so they could acquaint themselves with prevailing policies and procedures peculiar to the service, thus accumulating first-hand knowledge of the areas they would later supervise.

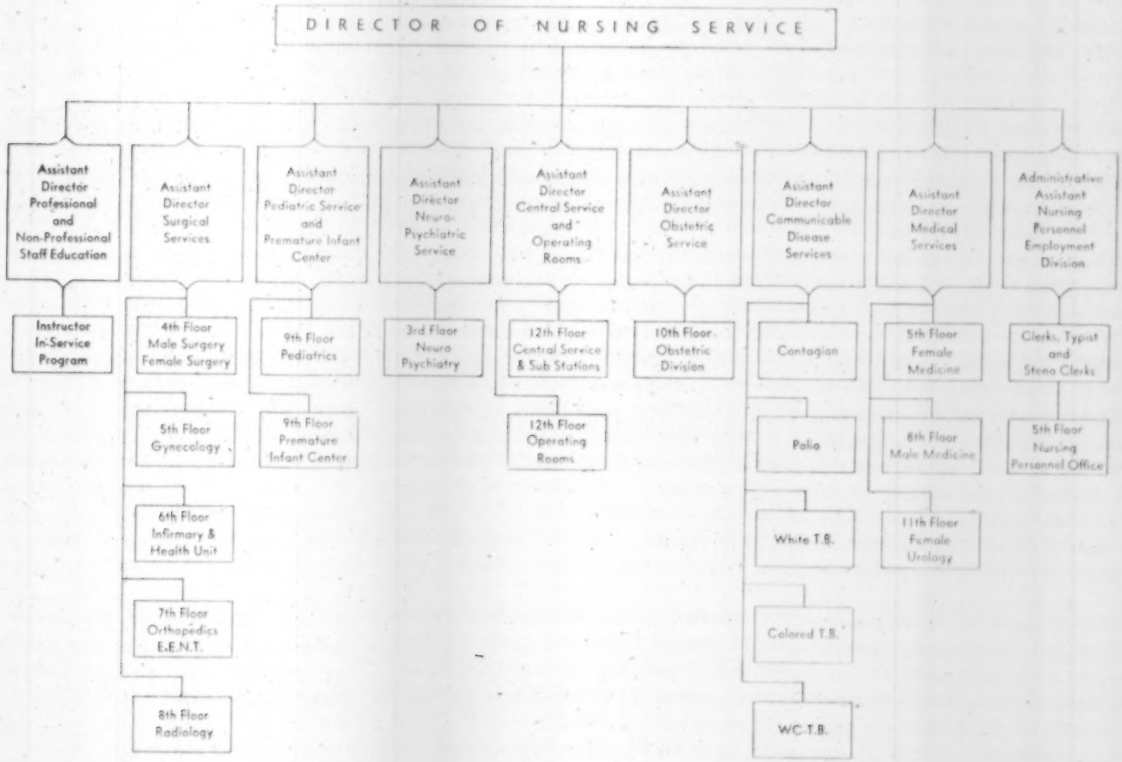
In the allocation of activities, care was taken that members of

the group were assigned one or more of the duties which constituted a part of the whole function of the Nursing Service Department and that all activities making up the complete function of the department actually were assigned. The primary end in view was to provide better service to patients: (1) By promoting a more adequate system of counseling and guidance to individuals on the hospital divisions through better policy formation and interpretation; (2) by providing for a more personal and direct contact with those on the divisions by representatives from the nursing service headquarters; (3) by providing for representation from the hospital divisions at nursing service headquarters so as to better interpret needs and problems; (4) by providing for the study of individual situations and problems by persons aware of the needs of not only their particular divisions but the entire department; (5) by employing the services of specialists in their respective fields to act as consultants in the care of patients.

The primary duties outlined for the director of nursing service are: To investigate major complaints or expressions of dissatisfaction with the nursing service; confer with members of the medical staff and heads of departments; make periodic rounds on the nursing units for supervision of the care of patients; transmit directives and information from the hospital administrator and the assistant administrators to the nursing personnel; keep the administrator informed of the general activities and any unusual emergency situations; assist in the planning of new divisions and renovations of old divisions; outline activities of the department for the yearly report of the hospital; outline needs of the department for budgetary purposes; direct preparations for study of nursing functions; keep informed of the activities of committees and make timely suggestions; interpret programs of national, state, and local organizations as they relate to nursing; keep staff informed of projects and changes; make contacts with organizations, i.e., the National Foundation for Infantile Paralysis, American Red Cross, council of social agencies, board of education, civil defense authorities; work with the hospital administrators on hospital defense program; coordinate activities of assistant directors of nursing service; exercise leadership in the accomplishment of the aims of the Nursing Service Department.

The assistant director in charge of professional and nonprofessional staff education will formulate and operate programs to meet the educational and inservice training needs of staff members. Her responsibilities will be to arrange regular meetings for the purpose of presenting programs and topics which will encourage and assist the members of the staff to secure better preparation for their jobs, improve the technical skill of the individual, increase efficiency, and promote understanding, cooperation, and job satisfaction; to arrange general meetings of the entire nursing staff with the director and assistant directors of nursing service in order to provide a means for the unification of the nursing service personnel as a co-

THE NEW ORGANIZATION


DIRECTOR OF NURSING SERVICE
Assistant Director Professional and Non-Professional Staff Education
Assistant Director Surgical Services
Assistant Director Pediatric Service and Premature Infant Center
Assistant Director Neuro-Psychiatric Service
Assistant Director Central Service and Operating Rooms
Assistant Director Obstetric Service
Assistant Director Communicable Disease Services
Assistant Director Medical Services
Administrative Assistant Nursing Personnel Employment Division
Instructor In-Service Program
4th Floor Male Surgery Female Surgery
5th Floor Gynecology
6th Floor Infirmary & Health Unit
7th Floor Orthopedics E.E.N.T.
8th Floor Radiology
9th Floor Pediatrics
9th Floor Premature Infant Center
3rd Floor Neuro Psychiatry
12th Floor Central Service & Sub Stations
12th Floor Operating Rooms
10th Floor Obstetric Division
Contagion
Polio
White T.B.
Colored T.B.
W.C.T.B.
5th Floor Female Medicine
8th Floor Male Medicine
11th Floor Female Urology
Clerks, Typist and Steno Clerks
5th Floor Nursing Personnel Office

ordinating and cooperative force; to secure guest speakers and audio-visual materials to present to the nursing personnel and arrange for group participation in the programs; to promote departmental meetings on each service at which the personnel on the service will be given the opportunity to present, discuss, and refer projects and problems of mutual concern; to plan and direct the orientation program for professional nurses and nurse technicians; to receive and plan activities of professional visitors; to direct and administer the nurse aide training program; to prepare periodic and annual reports of the staff education and inservice training programs; to assist in the planning, directing, and supervising of the Nursing Service Department; and to represent the Nursing Service Department in the absence of the director.

The inservice program instructor for auxiliary personnel will interview and select applicants for the nurse aide trainee course; teach a three months' course to nurse aide trainees four times yearly; assist in conducting organized inservice classes for other groups of nonprofessional personnel; make recommendations for changes in duties and work procedures for auxiliary personnel; compose periodic progress reports of the training program.

The administrative assistant in charge of the nursing personnel employment division will maintain immediate supervision of the nursing personnel office located apart from the administrative offices; assign routine office typing, filing, posting of records and attendance forms to a staff of seven clerical employees; maintain immediate supervision of all employment processing in conjunction with the central personnel office and with the accounting department; interpret hospital policies pertaining to illness, absence, and vacation; maintain a classification roster of all the nursing service positions; maintain complete record on all employees, past and present; compile monthly report of distribution of personnel in department; compile monthly report of employments and resignations; assist the director of nursing service with various statistical records, such as number of nursing care hours rendered to patients; compile information for questionnaires; compose correspondence regarding budgetary and personnel problems, subject to approval of director; dictate correspondence related to the employment of personnel; supervise the issuance of pay checks to nursing service employees.

The assistant directors for all services will participate as members of the administrative group in daily conferences concerning matters coming to their attention which are in line with their functions as assistant directors; prepare correspondence involved with the hospital divisions; recommend and implement establishment of policies; revise existing policies to meet the changing needs; assist in the development of procedures and methods in conformity with the advancement of medicine and nursing; participate in and promote staff education, orientation for nursing staff, and inservice program for nonprofessional personnel; interview professional nurse applicants for positions; make daily rounds in the hospital units to observe the nursing care rendered to patients and to analyze patient needs; investigate complaints or expressions of dissatisfaction of the nursing service; conduct conferences and discussions in cooperation with the division supervisor and other persons on problems in connection with ward administration and supervision; analyze and evaluate methods of ward management; review progress reports and counsel nursing personnel regarding their work; receive reports of accidents and follow up same; cooperate with the medical staff in planning total nursing care and in performing research or experimental projects; coordinate the activities of the various hospital departments with nursing service; promote and maintain harmonious relationships among the medical staff, nursing personnel, patients, and others; define and interpret activities for all levels of nursing service personnel in cooperation with a joint committee from the Department of Nursing Education; assist in the preparation of the budget and annual report of the Nursing Service Department; attend meetings in the community which promote advancement in nursing.

The group holds itself responsible for the standards of nursing care in the department except for existing limitations with regard to budget and personnel. The advantages of group thinking have been clearly demonstrated: Many minds are brought to bear on a problem; many minds are productive of many ideas; many ideas produce sounder conclusions. It is, therefore, on the basis of group thinking, group planning, and group action, that the Department functions, and the experience of working and thinking together provides an opportunity for the promotion of good human relations.

Delegating duties to each assistant simplifies the work of the director and provides an opportunity for better administrative planning. The matter of assigning activities, of supervising, and of coordinating became simpler because of this joint sharing of responsibility. In no sense did the delegation of authority weaken or lessen the final responsibility of the nurse administrator. Shifting of responsibility played no part in the plan. Unlike the experience of the director who asked the supervisor of a division to take care of a matter, who in turn asked the head nurse to take care of it, who in turn asked the general duty nurse to take care of it, who in turn asked the practical nurse to take care of it, who in turn asked the nurse aide to take care of it, who in turn asked the custodial worker to take care of it, who in turn didn't take care of it, it is hoped that in this new system, no such weakness will be experienced, and that through a coordinating process, better results will be seen.

All this has not been accomplished without consistent effort, but the effort has been most worthwhile, for as Carlyle says: "Change is painful yet ever needful, and since we ourselves change, how can our works and thoughts, if they are always to be the fittest, continue always the same?"

Inter-Plan Service Benefit Bank reaches milestone of service

HAROLD BAUMGARTEN JR.

ANOTHER MILESTONE of service to hospitals was reached last month by the Inter-Plan Service Benefit Bank of the Blue Cross Commission. The Bank paid for its four millionth day of patient service.

The Inter-Plan Service Benefit Bank is a mechanism established by contractual agreement among Blue Cross Plans through the Blue Cross Commission of the American Hospital Association, to accomplish two purposes. First, it allows a Blue Cross subscriber to use his Blue Cross membership as effectively and as easily when he is away from home as when he is in his home Plan area. Second, it gives the Blue Cross member hospital a quick, reliable and simple system for the establishment of credit for the hospitalized out-of-town Blue Cross patient.

In only three and one-half years the Inter-Plan Service Benefit Bank, created by Blue Cross Plans as a service to hospitals, has proved of great value in alleviating the time-consuming and costly task of securing references or collections for out-of-town patients. The Inter-Plan Service Benefit Bank has saved many thousands of dollars in collection and credit costs, and serves as a local citizen accompanying the Blue Cross patient to the hospital admission desk. The Bank offers a credit guarantee within hours after the admission, almost invariably by the end of the first 24 hours of care.

Through the Inter-Plan Service Benefit Bank, virtually all of the 42 million Blue Cross subscribers are able to receive service benefits when hospitalized away from home. Each month over 18,000 Blue Cross subscribers are admitted to hospitals out of their own Plan area and receive Blue Cross service benefits. Each month there are 18,000 credit and collection problems solved for hospitals through this effective program.

The concept of Blue Cross, that of having local Plans with local autonomy, created a problem for out-of-town Blue Cross admissions. The solution, as it now functions, does not in any way conflict with the original concept which today has made Blue Cross the greatest single factor in the financing of hospital care. The Bank, however, does avoid several other problems. Without the Bank, in order to give service benefits, hospitals would have to learn and know the benefits of the multitude of Blue Cross certificates offered by 80 Blue Cross Plans in the United States, Canada and Puerto Rico. It is, of course, not practical for each of these Plans to contract separately with 6,000 hospitals across the North American continent.

In a few words, here's how the Bank works. Suppose that a subscriber from the Chicago Blue Cross Plan was hospitalized in Boise, Idaho. He would be admitted to the hospital just as though he were a member of the Boise Plan and would receive the same service to which a local member would be entitled. The hospital would notify the Boise Plan of the admission. Boise would telegraph Chicago asking it to confirm the membership and eligibility for benefits. The Chicago Plan must make the confirmation within 24 hours.

Having received telegraphic confirmation of his eligibility for benefits, the Boise Plan notifies the hospital. Later, the bill is paid by the Boise Plan through its regular payment to the hospital.

The Bank reimburses Boise for this payment and charges the Chicago Plan in an amount determined by a formula related to both the actual cost of the care in Boise and the average cost of care in Chicago Blue Cross hospitals. Debits and credits are made to the Plan's deposit accounts in the Bank and at the end of each quarter the balance is adjusted to the amount of deposit each Plan is required to maintain in the Bank.

The reasons for the phenomenal growth and success of the Bank can be found in the hospital admitting offices in areas served by the Inter-Plan Service Benefit Bank. The hospital office staff knows that the benefits received by the "out-of-towner" are the same as the local Blue Cross subscribers. They deal with the same people in the local Blue Cross office and they are assured of a rapid reply on the "out-of-towner's" eligibility for benefits.

The Inter-Plan Service Benefit Bank began operating in May 1949, following more than two years of research and tests to establish its practicability. Its operation is essentially that of a clearing house for cases of subscribers out of their own area.

The wisdom and success of this venture is illustrated through the fact that in the few years the Bank has been in operation, it has cleared more than 454,000 cases. Payments for "out-of-towners" equal more than 44 million dollars.

Today, the Bank is indispensable to Blue Cross Plans for it enables them to render better service to subscribers. Most important, however, it has extended the service benefit principle of Blue Cross beyond the provincial limits of local operations.

The Inter-Plan Service Benefit Bank is dedicated to the hospital "industry" as a mechanism to provide a simple admission procedure, prompt payments and good public relations with the "out-of-towners."

Mr. Baumgarten is manager, hospital relations division, Blue Cross Commission, American Hospital Association, Chicago.

Focus on TOMORROW'S HOSPITAL COSTS

W. D. BRYANT

HOSPITAL COSTS may be considered from several aspects. Sometimes the total cost of operating a given hospital each month is studied. Costs per bed day in a given hospital may be analyzed, thus permitting comparisons with costs in other hospitals. This approach is somewhat similar to studying hotel costs in terms of cost per room regardless of occupancy. If hospital costs are related to patient days, occupancy is considered as an important item in the distribution of overhead costs. This method of analysis is the one which is used most often today.

It is useful also to study hospital costs in relation to the length of patient stay. This approach considers cost from the standpoint of the patient; it permits one to study the cost of illness. It permits us also to relate the question of turnover of hospital beds to cost. Finally, an analysis of hospital costs in relation to hospital revenues may be made.

(Each of these various approaches to hospital costs will require different data, and it is essential that the approach be clearly indicated before detailed analysis is offered. The charts presented on page 64 illustrate past trends for a number of the factors affecting hospital cost.)*

Once the basic data in the charts have been assimilated, we may consider what have been the major factors in changing hospital costs. First are the increased prices which must be paid for hospital supplies and equipment. These increases are the result of business cycle phenomena. At the end of World War II there had developed a huge backlog of purchasing power due to the large number of persons employed at relatively high wage levels and to the fact that their income could not be spent on desired goods. In addition, there was a large deferred demand not only for consumers goods but also for producers goods which had not been available for civilian purposes. Although production increased greatly after the war ended, it could not do so rapidly enough to keep prices from rising.

The Korean War created a demand for defense goods which started the economy in an upward spiral again when it had appeared, for a time, that the deferred demand was being satisfied. The increased defense activity supported and increased incomes and these were translated into a demand for goods and services which caused prices to increase.

The rising payroll (personnel) costs experienced by hospitals have been a second factor in higher costs. Hospitals have found it necessary to pay higher wage rates because their employees had to meet the higher costs of living; because other industries which needed employees were offering higher wage rates, thereby increasing the competition for labor; and, in some cases, because labor unions began to organize hospital workers and to bargain collectively for their wage rates.

Rising payroll costs may have been due, also, to the decrease in hours of labor per day for hospital employees. This shorter work day has been forced on hospitals by the competition for labor with other industries. Changes in working conditions such as the mid-morning and mid-afternoon rest periods are often regarded as a cause of increased costs because they decrease the hours of labor worked. It should be noted, however, that they may increase the output of work per day if handled effectively.

Another influence increasing payroll costs in a number of hospitals has been a decline in job morale and an increase in turnover among hospital employees because of the competition for their services and the failure of the hospital to meet this competition immediately.

A third general economic factor affecting hospital costs has been the availability of consumer purchasing power which affects the demand for hospital services and the nature of that demand, *i.e.*, whether it is for more or less expensive accommodations.

Demand for a hospital's services is somewhat different from that for the usual business product. It includes "need" apart from ability to pay, as well as "economic demand." A businessman makes his plans on the basis of estimates of the amount of goods he can sell at a given price in a given community. A hospital knows that it will

Mr. Bryant is executive director of Community Studies, Inc., Kansas City, Mo. This article is adapted from an address presented at the Kansas Hospital Association meeting, November 1952.

*Data for these charts taken from the Journal of the American Medical Association and the United States Department of Commerce.

provide some services regardless of the patient's ability to pay because the society in which we live has agreed that medical care in a hospital is so essential for some conditions that people must have it whether or not they can pay for it.

Charitable hospitals, whether governmental or private, operate primarily in the area of need. All hospitals, however, are affected to some degree by this concept of need for their services; hence they provide some free or part-pay beds.

Because of the relatively high levels of employment and wages since 1940, consumers have had more income with which to pay directly for hospital services as well as income which could be spared for hospitalization insurance. This has brought about a greater demand for private and semiprivate accommodations and services and a lesser demand for ward accommodations. It has affected the income received by hospitals and to some extent the expenditures. However it has affected some hospitals more than others. A hospital which can provide sizable amounts of private accommodations when necessary is adaptable to such a shift in demand.

A fourth factor affecting hospital costs is the occupancy rate. Too low an occupancy rate affects costs adversely because available space is not used while overhead costs for this space continue.

The national average rate has been below 80 per cent since 1934, except for the two years 1947 and 1948. There is, however, a wide variation in occupancy rates today. Of course, the occupancy rates reflect the number of potential patients in a given area as well as the availability of beds.

Advances in medical science and practice which have resulted in more complex and varied diagnostic and treatment procedures have been another factor in rising costs. This was discussed by Dr. Karl S. Klicka in a recent article in HOSPITALS.*

The shorter stay per patient made possible by scientific advances may also be a component of rising hospital costs. As it is well known, a patient uses more services and equipment during his first days in the hospital than during the later days. Hence, when more patients in an acute state of illness are using the hospital, the total expenditures of the hospital increase and the cost per day rises.

Increasing the number of short stay patients causes additional work for practically every department in the hospital. This, however, results in a greater use of the overhead facilities of a hospital and a better distribution of overhead costs than would otherwise occur. The total costs per unit of service in the hospital decline with effective use of facilities and personnel. The community is better served since more patients who need the diagnostic and treatment facilities can have access to them.

Of course the shorter stay means a reduction in cost of his total illness to the patient. Not only does he have to pay for a smaller number of days of hospital care but he usually is able to return to gainful employment more rapidly. Furthermore, because the overhead cost of facilities has to be charged to patients, the individual patient can gain when hospital facilities are fully utilized and the costs are spread over a greater number of patients. In fact, the maximum reduction in cost to the patient would probably come about if he could be moved rapidly from the general acute illness hospital to a convalescent building without diagnostic facilities and therefore with lower overhead costs.

Another factor in cost is the efficiency of hospital operation. Efficiency can offset some of the factors increasing costs. Many hospitals are now operating well below the maximum efficiency which is possible if the most modern techniques are used. Many hospitals are now in antiquated buildings which make it difficult or impracticable to use the economical procedures possible in modern buildings.

Many hospitals have inadequate accounting systems which tell them little or nothing regarding the financial aspects of their operations. The general administration of hospitals, in many cases, is more expensive than it need be if, for example, better personnel policies and practices are followed. Some hospitals find it difficult to influence the length of stay of their patients. This was pointed out by the American Hospital Association "Study to Determine Means of Reducing Hospital Costs."

What does the future hold for hospital costs? Let us consider first the general economic factors which affect these costs. The level of general business activity and production affects price levels, demand and wage rates for labor, and consumer purchasing power. These in turn affect the hospital through their effect on the cost of supplies and equipment, payroll costs and the demand for hospital services.

Is there likely to be a reaction in business activity in the near future?

In the past, a business recession has tended to follow a cutback in a program of providing producers plant and equipment, such as may occur in current defense activity, whenever this program has been large enough to produce a sizable amount of economic activity.

Will such a recession be of minor or major consequence? It is true that there is a smaller backlog of deferred needs for goods, and that assets in the hands of consumers and of business have a lower purchasing power than was the case at the end of World War II. Offsetting this, however, are a number of factors which make it seem probable that adjustment problems will be less than at the end of the last war. Of course, if a full-scale war should occur, it would change the picture completely. It is, however, the consensus of most economists and business forecasters that the next six to twelve months will provide a high level of business activity.

The demand for private and semiprivate accommodations and for beds in privately controlled hospitals will tend to be maintained if consumer purchasing power remains high as a result of high levels of employment. Even if a business recession occurs, the net effect of both declining income and

*"Does Medical Practice Affect Hospital Costs?" Karl S. Klicka. HOSPITALS, November 1952. Pp. 62-64.

CHART 1 presents data for the years 1934-1951 on number of admissions and beds, on per cent of occupancy and on average length of stay. These figures are expressed in index numbers with the figures for 1934 regarded as 100. Admissions to hospitals have increased approximately 180 per cent since 1934. The number of beds has increased only 45 per cent during this period. Per cent of occupancy has increased only 28 per cent. Finally, it can be seen that the length of stay has declined since 1934 by 36 per cent.

CHART 2 presents in millions of dollars estimates of the total amounts spent by persons in the United States for the services of privately controlled (nongovernmental) hospitals and sanitoriums, for physicians' services and for drugs and sundries. Note that personal expenditures for services in private hospitals and sanitoriums did not decline during the depression years 1931-1933. Rapid increases began about 1941. By 1950 the total expenditures for private hospitals and sanitoriums had increased from 403 million dollars in 1929 to about 2 billion dollars, an increase of 385 per cent. By 1950, expenditures for physicians' services had increased from 9.6 million to 2.4 billion dollars, an increase of 148 per cent. There was an increase of 140 per cent in expenditures for drugs and sundries. These increased expenditures resulted from rising prices as well as from the greater amount of services and goods purchased.

CHART 3 illustrates the effect of rising prices; it shows the extent to which the purchasing power of the dollar has declined since 1935. Purchasing power in this case is expressed in index numbers measured by retail food prices, wholesale prices, and the prices of those consumer goods and services which are factors in the cost of living. Averages for the years 1935-1939 were taken as 100. In each case the dollar purchased about 100 cents worth of these items in 1935. By mid-1952 its purchasing power had declined to 43 cents for retail food prices and about 50 cents for wholesale prices and consumer goods.

CHART 4 presents information relative to the increase in payroll, or personnel, costs. It shows the average hourly earnings in five selected industries. For example, in the manufacturing industry, the average earnings in 1935 were less than 60 cents, but by mid-1952 they were over $1.60 an hour. These trends illustrate the rising wage rates with which hospitals have found it necessary to compete in order to obtain and hold labor.

CHART 5 shows the changes which have occurred in 10 private hospitals in Kansas City in their average cost per patient day and cost per patient stay. It reveals that although the cost per patient day has risen almost 50 per cent, the cost per patient stay has increased only about 30 per cent. It illustrates the effect of the decreasing length of stay in Kansas City hospitals.

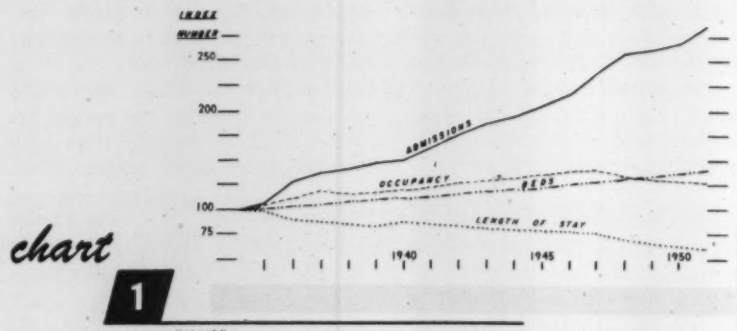


chart 1

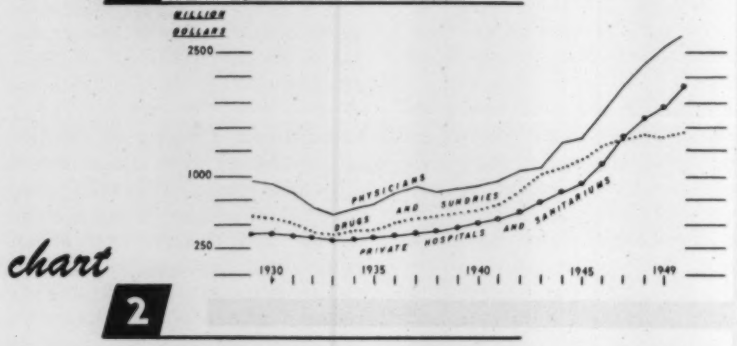


chart 2

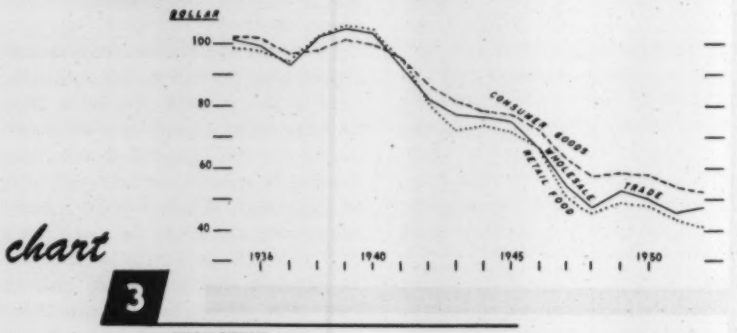


chart 3

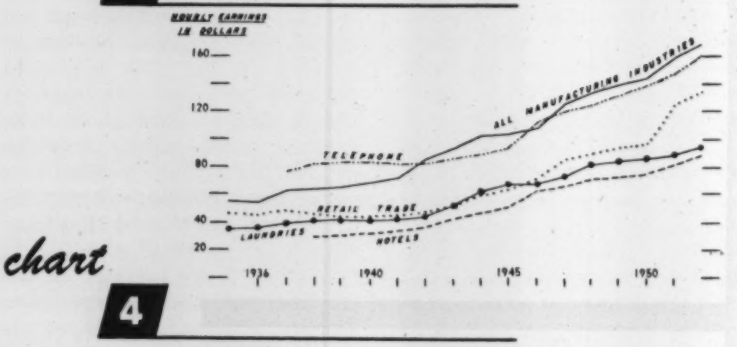


chart 4

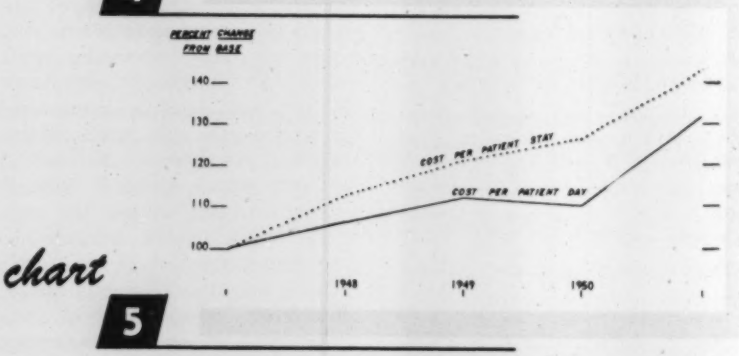


chart 5

falling prices may permit this type of demand to continue. For example, if prices fall more rapidly than do incomes, consumers are in a better position to purchase the more expensive accommodations than if incomes fall faster than prices.

Support may also be provided for this demand by the sizable amount of hospital insurance which is outstanding at the present time. About one half of the population has such insurance today. Because this type of insurance is relatively new, we have no experience to tell us much about the extent to which people will drop their hospital insurance when incomes begin to decline. However it seems reasonable to assume that a relatively strong support will be provided from this source at least in the initial stages of a recession.

Hospitals, therefore, may expect to continue to pay relatively high prices for supplies and equipment and high wages for employees. Competition for labor with other sources of employment and increasing unionization may produce even higher wage rates and shorter hours. The extent to which this results in higher costs per unit of output will depend upon the ability of the individual hospital to utilize effectively the services of its personnel.

The hospital occupancy rate is, of course, affected by the availability of consumer purchasing power. And, as we have seen, such changes affect quite differently the demand for hospital services in pay, part pay, and in free beds. Thus, the demand for services in public hospitals increases with a decline in purchasing power.

Other elements influencing the occupancy rate are: The number of new hospitals constructed and change in birth rate and in the type and amount of disease. First, it may be said that there will probably be no great increase in the building rate of hospitals. In fact, with the growing emphasis on economy in public spending a decline in the building rate may occur.

It is possible, although not certain, that the birth rate may decline somewhat which would mean a decreased demand for hospital beds for maternity cases. Because of the increase of the older population, however, there undoubtedly will be a growing demand from persons suffering from diseases of the chronic or long duration type. It recently has been estimated that persons aged 65 or older who, at present, require 26 per cent of the bed space will require 34 per cent by 1970.*

Will medical practice continue to increase in complexity and hence in cost? It probably will. Research is continuing at an increasing rate and there is no reason to believe that changes and improvements in medical and surgical care will decline. Moreover, prices of new drugs and new equipment tend to be relatively high when they are first placed on the market.

The shorter stay for hospital patients is, as we have seen, one result of change and improvement in medical practice. Will average length of stay continue to decrease? For acute illness cases it may, as more doctors adopt the early ambulation technique and as there are new developments in chemotherapy. There may be some increase in the length of stay as a consequence of the development of rehabilitation techniques, and as a result of a shift from acute to chronic illness. This shift may be caused not only by the growing proportion of aged in our population, but by the success of medical experts in preventing acute disease. If, however, chronic disease is cared for increasingly through home care programs and convalescent homes, average length of stay in general hospitals may continue to decline.

Finally, will the efficiency of hospital operation increase sufficiently to offset some of the economic factors tending to maintain high costs? Although it is impossible to forecast the degree of increase, it is almost certain that recent improvement will be continued. The number of better trained administrators is continuing to grow, and more and more emphasis is being placed on efficiency in hospital administration. Buildings are gradually being modernized, although this is a very slow process. Good accounting practices are also being slowly installed and much can be expected from this source in the future.

Better personnel practices and policies are also being adopted by hospitals and it is hoped that sizable cost reductions will be secured from this source. Hospitals are only beginning to experiment with a rearrangement of nurses' work so that they can delegate routine or non-nursing functions to properly supervised but less highly trained and lower paid personnel. In general, too few hospitals realize the extent to which savings have been made in industry through new techniques of personnel management. For example, it is often possible to decrease personnel cost per unit of output by increasing wage rates and thereby securing more efficient personnel.

Group purchasing with its attendant savings, and standardization and simplification of materials will probably be adopted more widely.

Finally, costs may be reduced through more effective use of all the resources of a region or a community with respect to professional personnel and equipment. Coordination among hospitals in the use of the most expensive scientific apparatus and the most highly trained specialists is far less expensive than building new facilities and training highly paid personnel who might not be used full time.

In conclusion, it is clear that there are two kinds of costs which face hospitals. First there are those which fluctuate with business cycle conditions and which are almost completely beyond the control of independent hospitals. Prices, wages, and the income available to pay for hospital services are of this type.

There are also other hospital costs over which the hospital has some control. The efficiency of its operation and the success with which it deals with changes in medical practice will affect costs of this type. It is to the best interest of the hospital to understand this difference in costs, and to take all possible steps to reduce those costs which it can control.

*"The Growing Problem of Chronic Disease Among the Aged" *Journal of the American Medical Association*, September 20, 1952. p. 206.

Public relations institute stresses the importance of

"the little things" in daily hospital routine

IRENE F. McCABE AND WILLIAM I. CHRISTOPHER

EARLY IN September, the Greater St. Louis Hospital Council sponsored a one-day public relations institute for the benefit of admitting clerks, switchboard operators, dietitians, janitors, nurses aides, nurses, attendants, technicians and others in St. Louis hospitals who come in direct contact with patients. The sessions were held in Brown Hall on the campus of Washington University.

There was no walking in and out of the meeting; no sitting quietly without participation. This audience listened attentively and participated actively in the discussions and afternoon workshops.

Subcommittees were appointed to develop plans to attack the problem of employee relations with patients, their friends and relatives and communications with the general public. A research committee was also appointed to gather material for use by the external committee.

The internal committee, made up of personnel directors from local hospitals, studied the problem and came up with the recommendation that no amount of publicity will overcome the thoughtless deeds which are committed each day by hospital personnel.

The hospitals in the council agreed to x-ray themselves at a one-day institute for the people who do not ordinarily have an opportunity to attend meetings or air their problems or opinions.

COMMON COMPLAINTS

Great care was taken in selecting speakers and panel leaders and the results more than justified the efforts. The program included a definition of public relations by Alfred Fleishman, well known public relations consultant. Fleishman gave a long list of the common gripes the public voices against modern hospitals. All are caused, he said, by the fact that institution leaders seem to have forgotten the fact that they are dealing with human beings and their families, all of whom are emotionally upset to a great degree.

"It's true that we have a lot of wonder drugs these days and they do achieve miraculous results, but we in hospital work must not expect these wonder drugs to solve all of our problems. We've got to admit that our human relations are bad," Fleishman said.

"There's nothing that can take the place of individual attention given to patients. We must re-evaluate how we're doing with the people. Sick people are hungry for kind words, sympathy and understanding. When they get it, they will return it a hundredfold."

The conference was not directed at hospital officials alone; doctors came in for their share of the public's growing antipathy toward institutions.

Fleishman dwelt at length on the biggest public complaint against hospitals—the reception desk.

Too many people are put through an intense "third degree" as they enter the hospital. Often in pain, they are interrogated at length on their name, address, place of birth, age, next of kin, place of employment, personal habits, membership in various organizations, financial status and other data, none of which pertains to their immediate physical condition. Finally they are told how fortunate they are in obtaining a bed in the hospital.

It was pointed out by panel speakers later that the attending

Mrs. McCabe is executive secretary, Greater St. Louis Hospital Council, and Mr. Christopher is personnel director, De Paul Hospital, St. Louis.

physicians often could spare the patient some of this ordeal by furnishing the hospital authorities with such information, especially when hospital reservations are made before the patient enters the hospital.

When the patient is finally in bed and is taken care of, then the relatives come in for their share of trouble at the switchboard or reception desk. They get such retorts as, "What's his room number? Who's his doctor? Did he have an operation? What's the matter with him?" The caller knows the answer to none of these queries, and ultimately is told to find out what he's talking about before he bothers busy people.

In the Army, Fleishman said, it was even worse for the patient than in civilian hospitals.

Fleishman concluded by reminding the hospital staffs to keep their nurses, aides, interns and other employees aware that they are dealing with human beings. People just can't stand being pushed around by overworked hospital personnel who are frustrated because of inadequate facilities and employees in such institutions.

It's the little things around the hospital that make the big difference with the patient and the public.

"Everybody," Fleishman said, "likes to feel that he is somebody —don't you? Every time you try to shame someone through this ignorance, in the presence of others, you have hurt that person deeply. Our juvenile penal institutions are full of boys who are there just because nobody made them feel like they are somebody. The school boy comes home some day feeling mighty happy—just because the teacher made him feel important that day. Hospital employees must remember that the patient is not such because of his choosing. He's sick and needs all the kindness and help he can get, and all the wonder drugs and scientific equipment can't replace those needs.

"Hostility begets hostility. When you shout at someone, you'll usually get a shouted reply.

"Remember the Golden Rule—don't just mouth it. Treat people like you would have them treat you, if your places were reversed."

COURTESY FILM

Following Fleishman's talk, a movie on courtesy was shown. This film showed the right and wrong relationships between employer and employee, and between employee and the public. It pointed up the truth that a courteous attitude toward all associates results in a better working relationship, and a better impression on the public.

Discussing some of the problems the administrator faces, Harry Panhorst, associate director, Washington University Clinics, said that good management of a hospital will result in good employees. If the employees are happy and cheerful, their attitudes will be reflected by their patients. He added that every employee wants recognition for his good work, good pay and working conditions with opportunity for advancement and a sense of security. The management of one hospital took all of its employees on an excursion on the river. Those employees are happy in their jobs, Panhorst said.

Good will toward employees, patients and the public automatically will bring good public relations, Panhorst said.

DRAMATIC SKIT

A 30 minute skit, designed to dramatize some of the bad impressions made on the public, was presented. Committee members realized that the skit could be tremendously effective or a total failure. Adolph Vedder, who has directed many amateur performances, volunteered to direct, and injected much life into the script. The cast was made up of amateurs recruited from members of the council. Panel leaders discussed some of the situations highlighted in the skit.

WORKSHOPS

The afternoon program consisted of workshops conducted by panel leaders from the different hospital departments represented.

Most employees felt the institute was a well planned, well executed program. The morning session where one could learn by listening; the afternoon discussions with individual participation.

Some derived the most good from Mr. Fleishman's address, while others expressed the opinion that they benefited from the panel discussions, the skit or from the movie, depending on their own particular problems.

Many suggested possible improvements for future institutes, such as having an authority working with the leader in each workshop to assist with problems presented by the audience. Several people suggested the workshop of nursing personnel be divided into smaller groups, such as head nurses, staff nurses and auxiliary personnel. Each group has specific problems and would probably feel freer to discuss them with people with similar problems.

All agreed that sharing ideas and discussing problems sometimes helps to solve them.

NEARLY 400 attended the one day public relations institute sponsored by the Greater St. Louis Hospital Council. Most of the audience found the dramatic skit highly amusing.

nursing education . . .

WHAT IT COSTS THE HOSPITAL

RAY SWANSON

WE AT Swedish Hospital in Minneapolis have always known that it is expensive to maintain a school of nursing, but since the many elements of this cost are so intermingled with hospital operating expenses we were able to estimate only roughly what our school of nursing was really costing. Last year, Donald E. Wood, an administrative resident at our hospital, made a detailed study of our costs for 1951, and the results were startling. In the accompanying article, Mr. Wood describes his study and what it revealed.

Briefly the figures showed that for 1951 the average cost to the hospital for each student in our professional school was $639.36, after giving credit for tuition received from students and after evaluating every hour of service rendered to the hospital by students.

When we say that this was the cost to the hospital, we are in effect saying that this was cost to our patients, for we have no outside source of income.

From a strictly dollars-and-cents standpoint, it would seem that our hospital should close its school of nursing immediately and reduce its costs by more than $100,000 per year. This, of course, was not the decision of the trustees, nor was it my recommendation. From a practical standpoint, where would we get 70 or more graduate nurses to replace the 130,000 hours of effective service rendered by students?

And if our hospital and all other hospitals closed such schools, where would we get any graduate nurses at all? The answer is that schools such as ours are essential to the continuance of the system of voluntary nonprofit hospitals in this country. With the crying need for more nurses, we must have *more* hospital facilities for educating student nurses rather than less.

BACKGROUND FOR STUDY

The Swedish Hospital is a 420-bed general hospital which in 1951 admitted 15,626 patients and had 3,246 births. For more than 50 years the hospital has maintained a school for student nurses which, over the years, has graduated more than 1,500 nurses. During the Cadet Nurse Corps program there were 235 students in training in our school at its highest enrollment, a figure which is equalled during the current 1952 - 1953 school year.

As was probably true with most voluntary hospitals maintaining nursing schools, our hospital prior to World War II considered that the cost of running the school was pretty well offset by the services to patients rendered by students. During the Cadet Nurse Corps program, the greatly increased costs of the school and the gradual reduction in hours of service by students were met by grants from the federal grovernment.

But as an offset to these income items, the hospital lost the services of the students during the six months when they were on affiliations, as required by the Cadet Nurse Corps plan. These affiliation periods were, of course, during the time when the students would have been of greatest service to the hospital. But all in all the Cadet Nurse Corps program helped the hospital to meet the marked increase in educational costs and the decrease in student services.

After the war ended and the Cadet Nurse Corps program was terminated in 1948, the hospital began to feel the impact of the great changes in costs of education which had taken place during the war period but which had been made temporarily painless by government subsidy. Since that time, the financial load for nursing education has become increasingly difficult to sustain.

Leaders in nursing education have been constantly pushing the standards for nursing education upward: Expanded curricula, more instructors, more classroom and laboratory facilities, more teaching supervisors and at the same time an ever-decreasing student nurse duty week (first to 44 hours and now to 40 hours) plus increased vacation periods and increases in the periods of affiliation away from the home hospital. In other words, more and more cost and less and less student service to the patient resulted.

Certainly no one is more interested in improved and expanded educational programs for student nurses than those of us who are responsible for managing hospitals and rendering service to patients. But the pressures for expanded education of students and at the same time for reduced service by students have been exerted by those who apparently have not considered the ability of our patients to pay for the greatly increased costs.

The Swedish Hospital, like other voluntary hospitals with nursing schools, found itself faced with a heavy financial burden for nursing education at a time when it was increasingly difficult to balance the hospital budget. That is what led to our detailed study, which Mr. Wood describes on the next page.

Mr. Swanson is superintendent of the Swedish Hospital, Minneapolis.

. . . nursing education

HOW THE COSTS ARE DETERMINED

DONALD E. WOOD

IN THE PROCESS of determining the costs of nursing education at the Swedish Hospital in Minneapolis for 1951, we had to consider the following factors:

1. Certain expenses are the direct result of the operation of the three-year program of nurse education and are incurred solely for the purpose of educating student nurses. These are the direct expenses of nursing education.

2. Certain expenses are the result of services rendered by other departments of the hospital to the school of nursing. A proper proportion of these departmental expenses must be allocated to nursing education. These are the indirect costs of nursing education.

3. Students pay a fee or tuition to attend the Professional Nursing School of the Swedish Hospital. This is income credited to the expenses of nursing education.

4. Students in the nursing school provide nursing service for patients in the hospital as part of their learning experience. This service of the students must be evaluated and proper credit applied to nursing education. This also is income credited to the expenses of nursing education.

At this point it would be well to differentiate between expense and cost. Expense is that portion of the value of a commodity or service that has been consumed during a particular accounting period and is chargeable to that period. Cost is the sum of all expenses allocated to a particular unit—a meal, a pound of steam, or an hour of nursing service. Cost, therefore, is the result of the breaking down and reassembling of expenses and the application of them to a particular unit.

Mr. Wood is executive secretary of the Hospital Council of St. Paul. At the time this study was made, he was administrative resident at the Swedish Hospital, Minneapolis.

DIRECT EXPENSES

The direct expenses of operation of the school of nursing are the most easily and accurately determined of all expenses. These are taken directly from the expenses that are incurred solely in the operation of the school.

The salaries of personnel engaged entirely in nursing education are, of course, direct expenses. The following personnel are included in this category: Clinical supervisors, nursing arts instructors, residence directors, librarian, and other personnel working only in the program of education. The total of these salaries was obtained from the accounting records and verified by a summary report of nursing department salaries.

Supplies and miscellaneous items used entirely in education are the second group of direct expenses. These include expenses incurred for special lectures and films, affiliation tuition, library books and supplies, graduation and capping, school supplies and equipment, recreation and choir, travel, uniforms, office supplies and printing, testing, textbooks, medical expenses and other direct expenses of operation. These expenses were obtained from an audit of the voucher register (charged to the account "Nursing Education") and the expense ledger for 1951.

Total direct expenses—$79,987.09.

INDIRECT EXPENSES

Indirect expenses are those that are not directly available from the accounting records of the hospital. They are costs that have been determined from existing accounting records and have been properly allocated to nursing education. The methods of computing or determining the proportion of nursing education cost differs with the department or service under consideration.

In the process of determining the costs of the various services performed by other departments for the Professional Nursing School of the Swedish Hospital, it was decided that the direct expenses of the departments involved were the expenses to be used for the determination of cost.

If the total cost of operating each department were to be computed, then the indirect costs should be included to give a total operating figure. But the indirect expenses of operating the service departments of the hospital would be included in the cost of the departments regardless of whether or not there is a school of nursing. Our job, then, was to find the cost for the services performed for the school of nursing from the standpoint of avoidable cost—that cost which would have been avoided if no school of nursing were operated at the hospital.

Any expense that was incurred as a result of the education of student nurses must be included as part of the total expenses of the school of nursing. These educational expenses would not have been a part of the total hospital expense if the school of nursing had not been in operation. Therefore, we use the term *avoidable cost*. Applying the concept of avoidable cost, the indirect expenses of operating the service departments are not included with the direct expenses when figuring costs for this report.

The first of the indirect expenses

of the Swedish Hospital school of professional nursing are those of salaries and wages. In addition to the personnel employed for the purpose of education only, many of the nursing personnel serve in a joint capacity—nursing service and nursing education. This group of personnel is composed of the director and assistant director of nursing, nursing supervisors, head nurses, assistant head nurses, clerical workers and others.

In order to compute what part of their time was spent in the education of students, a questionnaire was prepared and given to each of the above mentioned individuals or groups. Conferences were held with all personnel completing this form in order that uniformity and accuracy could be obtained. When the questionnaires were completed, the results were tabulated and a percentage of the salaries was allocated to nursing education, based on the amount of time spent in the education of students.

These salary figures were computed by means of a complete listing of all personnel of the nursing department and their salaries for the year 1951. Their salaries were then allocated to nursing service, nursing education (direct and indirect), and to practical nursing education. The totals of these figures is in exact agreement with the total 1951 payroll for the nursing department.

Total salaries (indirect) $29,435.46.

The allocation of administrative expense to the service departments of the hospital provides a difficult problem in a cost analysis study. The method used in this study was based on the relationship between the total administrative expense (salaries, supplies and miscellaneous) and the total payroll of the hospital. The administrative expense was computed as a percentage of the total payroll for the hospital.

In determining the amount of administrative expense to be allocated to nursing education, the total direct and indirect salaries of the nursing education department were used as a base figure for computation of administrative expense of nursing education. The total salaries of nursing education multiplied by the percentage figure of administrative expense to total payroll gave the total administrative expense of educating student nurses.

Administrative expense—$7,298.71.

In determining the cost of meals for the nursing students, the following method was used:

1. The total expense of the operation of the dietary department for 1951 was obtained from the accounting records of the hospital.

2. The total number of meals served during 1951 was obtained from the records of the dietary department and the average cost per meal was calculated.

3. The total number of student meals served during 1951 was obtained from the records of the dietary department. This total was then broken down into the categories of professional students, practical students, and students on affiliation from other hospitals to the Swedish Hospital.

4. The total number of meals served to the professional nursing students was then multiplied by the average cost per meal to arrive at the meal cost for the professional nursing school.

Dietary—meal cost—$121,552.17.

In determining the laundry costs for student nurses, we did not use the usual method of cost per pound of laundry. The cost per pound method of analysis does not take into consideration the large number of items to be starched, ironed and pressed in the student laundry. These items are the most expensive to process of all linens, and a poundage basis of cost analysis does not ordinarily take this into consideration.

The personnel and the amount of time required to process the student linen in the laundry was the basis for the cost determination in this study. This method of determination of cost gives a more accurate representation of the cost incurred for the processing of student linen. When the expense of laundry personnel was determined, the expense of supplies was added to give a total of all laundry expense for the processing of student laundry. The total of these expenses was then divided by the number of students sending linen to the laundry to arrive at an average cost of a student's washing per week. The computation of costs of student laundry took into consideration an increase in wages of the laundry workers as of March 1, 1951.

Laundry expense—$8,156.01.

The expenses of the operation of the Professional Nursing School for heat, light and power and maintenance and repair were determined by means of cubic footage figures. The figures of cubic footage areas of the individual buildings were obtained from the Minneapolis city assessor.

The total expense figures for this department were taken from the accounting records for 1951 and the cost calculated by means of the percentage of the total hospital area used for the education of student nurses.

Plant operation expense—$18,026.48.

Maintenance and repair expense—$12,178.52.

The insurance expenses of the student nurse education program are of two kinds: Fire and extended coverage, and workmen's compensation. The fire and extended coverage costs were calculated on the percentage of the cubic footage area of the hospital buildings occupied by the nursing school. All of the fire and extended coverage policies are blanket policies, and a total of the policies was made and a percentage of this total applied to nursing education.

The expense of workmen's compensation coverage for the student nurses was calculated from the established maintenance expense and insurance rates for Minnesota. The number of students receiving full maintenance from the hospital was the basis for the calculation of the premiums for the workmen's compensation insurance coverage.

Insurance expense—$698.93.

The expense of depreciation chargeable to the school of nursing covers the use of certain buildings for the education program. At the Swedish Hospital there are three buildings used exclusively for education. These buildings provide living quarters, classroom and library facilities, laboratories, and

recreation areas for the students. The total amount of depreciation expense is given below.

Depreciation expense—$12,080.

The expense of the housekeeping functions in the three buildings occupied by the school of nursing is included in this section of the report. Housekeeping duties are carried on by seven fulltime employees, and the total of their salaries is the expense figure given below.

Residence personnel—housekeeping—$14,680.98.

Total indirect expenses—$224,107.26.

The total of all expenses of the Professional School of Nursing of the Swedish Hospital is given below:

EXPENSES

Direct exepnses	$ 72,987.09
Indirect expenses	224,107.26
Total Expenses	$297,094.35

INCOME OF NURSING SCHOOL

Part of the income of the school of nursing is derived from student tuition. Students in the nursing school pay a stipulated amount of tuition for each year they are enrolled in the school. The 1951 total of student tuition is as follows:

Tuition income—$25,045.

The next section of this study was designed to give the Professional Nursing School proper credit for services of the student nurses while enrolled in the nursing school. During the period of education of a student nurse, she provides valuable nursing service as a by-product of her education. It is the purpose of this section of the report to properly evaluate this student service and include it as income of the nursing school.

In determining the value of student service, three factors had to be considered, as follows:

1. The number of hours of actual service to the hospital by the students in each of the classifications: Senior, junior and freshman.

2. The average percentage effectiveness of the nursing students as compared with graduate nurses in the work environment. These average percentage effectiveness figures must also be applied to each of the classifications: Senior, junior and freshman.

3. The hourly salary paid to graduate nurses at the hospital. From these three factors, the value of student services to the hospital was computed.

In computing the first of the above three items, the records of the office of the school of nursing were audited. The daily record of each student was audited. Affiliation days, vacation, leave of absence, sick leave, holidays and regular days off were deducted from the total number of days of training to arrive at the number of hours of student service. This service time of each student was allocated to the appropriate classification: Senior, junior or freshman. The resulting figures indicate the net number of hours of actual service in each of the class groupings.

STUDENT SERVICE HOURS

Seniors (third-year students)	56,110
Juniors (second-year students)	73,011
Freshmen (first-year students)	41,757
Total service hours	170,878

The determination of the average percentage effectiveness of the nursing students, as compared with graduate nurses in the work environment, resulted in the second factor which was required to calculate student value to the hospital. The determination of these effectiveness percentages for student nurses was the purpose of a study conducted at the Swedish Hospital by the nursing school office. Students in the nursing school were rated on a comparison basis. They were compared to the average graduate nurse in the same work environment. The final result was to determine how effective the student nurse is when compared to the average graduate nurse in the same situation. This study was designed to cover a complete year of operation. The results of the first 10 months of the study were made available for use in this report on cost of nursing education.

The thoroughness of the study of student effectiveness by the nursing school office cannot be overemphasized. Definite criteria for the determination of student effectiveness were established and were used by all personnel working on the actual evaluation of students. This was a continuing study for each day of the 10 months reviewed. For each 24-hour period, the head nurse, assistant head nurse, or a nursing supervisor wrote proficiency reports for each student assigned to her service or station during her duty hours. These reports then were tabulated and averaged to arrive at the student effectiveness figures. Therefore, these percentage of effectiveness figures included all students, all services, and all shifts of work. The results of this study are as follows:

STUDENT EFFECTIVENESS PERCENTAGES

Seniors (third-year students)	83%
Juniors (second-year students)	76%
Freshmen (first-year students)	67%

A third factor that was necessary in computing the value of student services was that of graduate nurse salary during 1951. The graduate nurses received a salary increase effective August 1, 1951, and this increase had to be taken into consideration when computing the value of student service.

From January through July of 1951, the hourly salary for graduate nurses was $1.1539. From August through December it was $1.241.

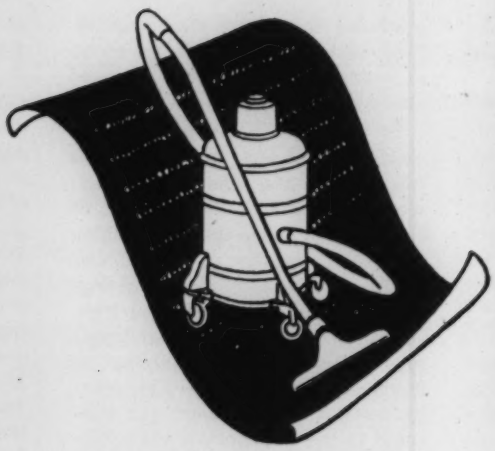
From the above three factors, the value of student service to the hospital was computed as $154,461.11.

The total of *all* income of the professional school of nursing, including the total value of student services, was calculated as $179,506.11 for 1951.

Probably the most interesting and most valuable figure from the standpoint of the hospital and future educational policy is the average cost per professional student nurse for 1951. This figure has been calculated with the following factors determining the final cost figure:

1. The total direct and indirect cost figures of the nursing school are used. These costs do not include expenses that have been incurred in the operation of the Practical Nurse School or expenses resulting from the affiliation of

(Continued on page 150)



CONTRACT HOUSEKEEPING SERVICE in a small hospital

CORA E. GOULD, F.A.C.H.A.

THE New Jersey Orthopaedic Hospital decided to experiment with a commercial porter service because three of five fulltime porters left the hospital within a period of two weeks to accept jobs in industry at about one and a half times the current wage scale paid by the hospital. Replacements were not available at the prevailing hospital levels, and to meet the scale paid by industry was neither feasible nor possible.

The New Jersey Orthopaedic Hospital Unit of The Hospital Center at Orange is a 41 bed specialty hospital. The services are housed in a three-story building. The floors are covered with linoleum, rubber tile, ceramic tile or terrazzo.

The men were first asked to spend one and a half to two hours a day, two days a week, to care for the floors. Now they are coming once a week for four hours to clean the corridors and rooms on an alternating basis. Heavy duty vacuum equipment is used to avoid stirring up dust by sweeping, and a floor filler preparation is spread and buffed. Wet mopping by our own men has been eliminated, except for the emergencies of "spilling" on the floor. Our own men now have eliminated brushing and use household size vacuums.

The experiment, as a whole, is most successful. The idea is sound and economical. At the end of the first three months we had saved $441.20 in salaries at the end of five months, $1,042; at the end of 11 months, $1,072.10. The proportionate drop in the 11 month figure was due to the assignment to the porter service of extra annual housekeeping chores and some night work for which there was no real comparative figure.

The intangible benefits include:

1. Fewer employees, reducing compensation insurance and eliminating the cost for sick leave and vacation time.

2. No equipment to provide or maintain with resulting financial benefits (capital expenditure and depreciation lessened).

Hospital housekeeping work and all functions of the "hotel nature" warrant at least a survey and an investigation by technical and commercial profit-inspired companies and organizations. In our hospital 7.7 per cent of the budget of $242,000 is laundry and housekeeping. In 11 months of 1951-52 we actually spent $12,491.70 for housekeeping items, compared to $13,702.25 for an equivalent period in 1950-51.

We have been asked the question, "Aren't you afraid to give up any part of administration?" Believe me, we do not "give up" anything. We are working with and through another administrator whose object in life is to stay in business. The satisfied customer is his goal, and profit thus acquired is his livelihood. This arrangement affords us more free time for attention to the more professional side of patient care.

It would be most interesting to see the development in this country of a porter service comparable to the New Zealand set-up so well described in the July 1952 issue of HOSPITALS.

We plan to extend porter services to other sections of our hospital as soon as the commercial porter service is equipped to handle the additional work.

It must be said that this "part-time" service cannot replace full-time hospital personnel 100 per cent because of the constant need for meeting emergency duties.

The conclusion to be reached is better floor care in less time, better supervised by trained personnel, whose standard of living rises in direct proportion to productivity.

Miss Gould is administrator of the New Jersey Orthopaedic Hospital Unit of the Hospital Center at Orange.

advance payments ??????????????

What are hospital policies

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HUGO V. HULLERMAN, M.D.

BECAUSE INFORMATION as to current practice was so scarce, the United Hospital Fund of New York last year set out to learn what hospitals are doing in the matter of requesting advance payment from inpatients.

A questionnaire was sent to 67 hospitals that are members of the United Hospital Fund. Fifty-six hospitals returned the questionnarie, and of that number, 49 had filled it out completely. These 49 completed questionnaires form the basis of our analysis. The 49 hospitals represent 14 of 19 general hospitals smaller than 200 beds, 19 of 25 hospitals between 200 and 400 beds, all eight general hospitals of 400 beds or more, and eight special hospitals.

Three main points were established by the survey:

1. Patients with Blue Cross or workman's compensation are least likely to be asked for advance payments.

2. Patients who are responsible for their own hospital bills (those having no hospital insurance of any kind) are most likely to be asked for advance payment.

3. Policies on requesting advance payments have, in general, been in force in individual hospitals for many years.

It will be noticed from the table of answers to our first question (reproduced on this page) that patients having hospital insurance other than Blue Cross are more likely to be asked for advance payment than those with Blue Cross. The fact that payment in certain types of insurance are made to the patient rather than to the hospital may be important here. Also this may partly explain the finding that patients with "union or similar payment guarantee" are less likely to be asked for advance payment than those listed as having "other hospital insurance" (not Blue Cross).

Whether a patient (who does not have insurance or union coverage) requests private, semi-private or ward accommodations has less effect on whether he is asked for advance payment than might be supposed. Thus 39 of the 49 hospitals request advance payment for a private patient who is personally responsible for his bill, while 44 of the 49 request such payment from a ward patient who is responsible for his bill.

From the chart it will be seen that there are three types of patients who are not asked for advance payments at any of the 49 hospitals. These are: Ward patients with Blue Cross, semi-private patients with Blue Cross, and ward patients who are compensation cases:

It is the policy of five hospitals never to request advance payments. Two of these are hospitals of 400 beds or more, two are between 100 and 200 beds, and one is between 200 and 300 beds.

Ten other hospitals limit their requests for advance payment as follows: Two (with fewer than 300 beds) request advance payments only from patients who are personally responsible for their bills —they do this regardless of whether the patient wants private, semi-private or ward accommodations; three hospitals request advances only from ward patients who are personally responsible for their bills; one hospital will ask advances from patients personally responsible if the patient wishes semi-private or ward (but not private) accommodations.

The hospitals were asked, "When advance payment is requested, please indicate how the amount of such payment is determined."

The answers may be analyzed:

- Requesting an amount equal to

Who is asked for advance payments?

The 49 hospitals which supplied information about advance payment policies gave the following answers to the first question:

I. Is it the policy of your hospital to request advance payment if the patient	Patient Private		Semiprivate Patient		Ward Patient	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*
(a) has Blue Cross insurance?	14	35	—	49	—	49
(b) has other hospital insurance?	34	15	34	15	30	19
(c) has union or similar payment guarantee?	20	29	18	31	13	36
(d) is a compensation case?	9	39	4	43	—	48
(e) is personally responsible for his hospital bill?	39	10	37	12	44	5

Dr. Hullerman is director of hospital services, United Hospital Fund of New York.

one week at room rate—*10 hospitals.*

- Requesting one week at room rate plus deposit for operating room for surgical cases (deposit ranged from $10 to $100)—*4 hospitals.*
- Requesting one week at room rate plus operating room deposit ranging from $28 to $200, plus an additional advance for laboratory of $5 to $20 (deposits varying according to accommodations)—*7 hospitals.*
- Requesting an amount equal to two weeks at room rate—*5 hospitals.*
- Requesting two-week advance, deposit, plus additional deposit for operating room ($15 to $150) plus laboratory deposit ($5 to $10, with deposits again varying according to accommodations)—*4 hospitals.*
- Requesting advance payments on a 10-day all-inclusive basis—*3 hospitals.*
- Requesting $100 flat advance payment—*3 hospitals.*
- Some hospitals did not fit into these categories. Several based their requests on ability to pay or on an anticipated cost. Several hospitals used a one-week inclusive rate.

It is not possible to determine from the survey answers exactly how long advance payment policies have been in effect, but it is possible to say that in general they have been in force for many years.

Ten hospitals, however, indicated that their present policy has been in effect less than five years. Two hospitals indicated that they intend to change their advance payment policy, and one hospital has the matter under study.

The questionnaire did not determine the direction in which change had taken place in the hospitals which have revised their policy in the last five years. One hospital, however, said that it had been found poor public relations to ask patients for advance payments. This hospital has discontinued the practice except for patients who are transferred from ward to private or semiprivate accommodations.

It cannot be inferred from the survey that hospitals with long-standing policies are the ones in which more patients are asked for advance payments. One hospital with many decades of service reported that it had never asked patients for advance payments at any time in its history.

The survey does demonstrate that there is a multiplicity of policies and procedures in New York City voluntary hospitals. Careful study by individual hospitals, the majority of which apparently have not changed their policies over many years, might shed more light on whether present practices are in the best interest of the hospitals.

Do the net advantages of advance payments offset the irritation and poor public relations which the requests sometimes create?

Do the expressions of dissatisfaction from occasional patients mirror the unspoken objection of most patients?

If the hospital urgently needs working capital obtainable from advance payments, does the method of determining advances provide the optimum amount of working capital in relation to operating costs consistent with favorable patient reactions?

Other than the need for working capital, what factors (excluding patient ability to pay) should determine the amount the hospital should request as an advance payment?

Have advance payments favorably affected the accounts receivable?

Is it a myth or a fact that advance payments lead a high percentage of patients to pay their complete bills promptly after discharge; and that the resulting reduction of undesirable patient attitudes created by unpaid bills more than compensates for the poor public relations which may be caused by advance requests?

Should the hospital do more to help the patient understand the hospital's collection policy and the reasons for it?

These are a few of the questions suggested by the results of the survey as being worthy of study periodically by individual hospitals in order to meet the need of the hospital for adequate income and understanding patients.

Now It's National Hospital Week

National Hospital Week will be observed this year for the first time May 10 through 16, the week in which Florence Nightingale's birthday occurs. In previous years hospitals have observed National Hospital *Day* on May 12.

The development from a special day into an entire week's observance is the result of action by the Committee on Women's Hospital Auxiliaries of the American Hospital Association, approved by the Association's Board of Trustees. Through the Committee, auxiliaries which are Type V members of the Association will promote the observance of National Hospital Week throughout the country.

Purpose of the week will be to highlight the year-round program aimed at public education about hospitals and their place in the community. It is expected that while directing community attention to hospital activities, auxiliaries will have an opportunity to point up the many service programs they conduct in behalf of the hospital and hence attract new members and volunteers.

The Association's public relations department is working with the auxiliaries committee in preparing a 1953 National Hospital Week kit, which will be sent to all administrators and public relations directors of hospitals and to presidents of auxiliaries which are members of the Association. The kit will contain program suggestions and ideas which may be applied to a full week's activities or to only a few days, as the hospital chooses. Non-member auxiliaries may purchase the kit for $1.50.

a NEW look at

third-party payments

CONSUMERS, purchasers and providers of hospital care met last month at Highland Park, just outside of Chicago, for the American Hospital Association's second three-day conference on method and amount of hospital payment by third-party agencies.

After an introductory general session the 75 participants in the conference were divided into four groups to discuss for two days the "principles" adopted at the first conference, held in 1951.

At the end of each day the leaders in each group pooled the results of the day's discussions, and the next day the groups had another opportunity to challenge the group leaders.

On the third day the composite of changes from all groups was reviewed by the entire conference. Those who made recommendations at variance with the majority thinking of the groups had a chance at this last session to present their point of view. After the debate of the final session was over, the changes made in the original principles did not seem great.

What came out of the conference, many felt, was an intangible accomplishment rather than a tangible one.

The intangible was the feeling of cooperation among consumers, purchasers and providers that made for a high degree of agreement. it created an atmosphere of friendliness, ease and humor.

Hospital administrators and other hospital respresentatives, Blue Cross, labor unions, public welfare agencies, American Hospital Association staff members—all concerned with third-party payments to hospitals—were given a send-off at the opening session with short talks by Dr. Madison B. Brown, executive vice-president of Roosevelt Hospital, New York City; George Bugbee, executive director of the American Hospital Association; Harry Becker, associate director of the Commission on Financing of Hospital Care, and Maurice J. Norby, deputy executive director of the Association.

The groups were led by Dr. Edwin L. Crosby, president of the American Hospital Association and director of the Joint Commission on Accreditation of Hospitals; J. Milo Anderson, director of Ohio State University Hospital, Dr. Brown and Mr. Becker. Chairman of the final general meeting was Dr. Albert W. Snoke, director of Grace-New Haven Community Hospital, New Haven, Conn.

Depreciation: Although the sessions generally went smoothly, there were some controversial areas of general interest. One struggle centered on funding of depreciation. Everyone agreed that depreciation was a valid item of expense in determining full cost to be paid by third-party agencies. But one group felt it should be included in full cost only if a depreciation fund was set aside and the money used for replacement. Another felt depreciation was an economic cost and whatever the hospital wanted to do with depreciation payment was legitimate without an accounting to a third party. The former group won.

Education costs: Another controversial point was whether hospital expenditures for training programs should be part of full costs paid by third parties. The conference voted that the cost of educational programs in hospitals beyond that which is incurred for services to patients should not be included in determining full cost of hospital care and services. It added, however, that net expenses for educational purposes may need to be recognized as a part of full-cost reimbursement until other funds are available.

Contributed services: A major difference of opinion centered about the amount of reimbursement allowable for contributed services of volunteers and other non-paid workers. A majority vote weighted heavily by representatives of purchasers of care favored the inclusion in reimbursable cost of only identifiable amounts expended for the training, maintenance and supervision of such workers. The minority producer group held to the position that hospitals employing this type of workers should be allowed equal amounts to those being paid for comparable services in those hospitals which employ and pay personnel for similar types of work.

Ceilings: Reference to the establishment of ceilings on amounts of payment was removed from the original set of principles. It was believed that such limitation is

not consistent with the basic principle of payment of full cost and unnecessary in view of the recognition by both hospitals and purchasing agencies that they have responsibility to control costs.

Uniform principles: After careful and extended debate the group agreed that hospitals, even though they may deal with a hundred or more third-party purchasers, should use the same principles in determining amount of reimbursement from all such agencies. A wide variation in present practices with respect to methods employed for determining payments to a single hospital was noted. Uniformity was the key to the discussion of this principle adopted by the conference.

Kept intact: Among the important original principles kept intact were the following:

"Agencies purchasing hospital services should pay the 'full cost' incurred in providing services for which they are responsible under their agreement with hospitals."

"Hospital charges to the general public should be related to cost."

"Interest incurred on capital or other indebtedness should be included in determining full cost."

"Hospitals should cooperate with third-party agencies in the study of such factors as admission, length of stay, extent and amount of services provided, and other factors that affect cost of services to agencies purchasing care, with a view to economical and efficient use of funds."

Another meeting: The conference recommended that another meeting be called for the purpose of giving further consideration to methods whereby both hospitals and agencies which purchase care can establish assurances that such care is produced and distributed in the most economical way possible.

After editorial efforts of a reviewing committee, the report of this second Conference on Method of Hospital Reimbursement and the recommendation for a subsequent conference will be referred for consideration and suggested action to the American Hospital Association's Council on Prepayment Plans and Hospital Reimbursement.

Hospital construction—1953

LATE IN 1952, the U. S. Department of Commerce issued two reports. Both pinpointed two generally accepted facts: (1) Hospital construction has not kept pace with population growth; (2) hospital construction volume will continue at a near-record level in 1953.

The report on the pace of hospital construction was part of a broad general business report on markets after the defense expansion.

Though not a major part of the report, the reference to hospital construction was significant and thought provoking.

BUILDING LAGS

Said outgoing (with the Truman administration) Commerce Secretary Charles Sawyer, "Institutional building has not kept pace with population growth in recent years. The prosperity of the postwar years has been accompanied by an exceptionally large population growth. In September 1952, the total population of the United States (including the Armed Forces overseas) was 157.5 million, an extraordinary increase of 18 million since 1945.

"A substantial volume of construction is needed to bring hospital facilities up to standard.

"The near-term prospects are for increases, although the extent of the rise is limited by the ability of private and state and local sources to finance the needs."

This Department of Commerce report lent impact to another federal government agency conclusion of almost a year ago. At that time the Public Health Service, upon completing a statistical analysis of progress of building programs to meet the needs for community health facilities, gloomily reported that less than 55 per cent of the nation's needs were being met.

CONSTRUCTION OUTLOOK

The second year-end report was embodied in a joint statement issued by the Departments of Commerce and Labor.

In it, the two federal agencies predicted that hospital and institutional construction during 1953 would be the fifth best on record —with $725,000,000 to be laid on the line. In 1952 the figure was an estimated $866,000,000, second only to the $916,000,000 of 1951.

From 1931 to 1945, hospital and institutional construction never did top the $200,000,000 mark, and much of the time during those 15 years was reported at less than $100,000,000 annually. Even with the element of inflation considered, hospital construction is in a golden postwar decade . . . with the goals still elusive of attainment.

Of the $725,000,000 to be spent in 1953, slightly less than half will be spent by private sources—$350,000,000. The larger share ($375,000,000) will be spent by government groups—federal, state and local.

Private construction is easing off more slowly. The drop in government outlays can be traced in a large part to virtual completion of the Veterans Administration program of hospital construction and partly to reduced funds for the federal aid program that is part of the National Hospital Survey and Construction Act.

What might be a leveling off point beyond 1953 for hospital and institutional construction was a topic for some professional and unofficial prognosticators. The figures on the horizon seemed to add up to $600,000,000 to $700,000,000 annually.

EDITORIALS

Aim of the American Hospital Association: To promote the public welfare through the development of better hospital care for all the people.

A needed evaluation

FOUR MAJOR STUDIES to evalute the nation's voluntary health insurance plans, recently announced by the Health Information Foundation (see news department), should certainly be welcomed by hospital and health leaders. The purpose of these studies is to obtain basic information on the effectiveness of voluntary health insurance plans, gaps in the protection they provide, methods for improving and extending them more effectively, how the public is utilizing the protection they now offer, and the types and scope of additional protection the public would like to have and is willing to pay for.

In the words of Admiral W. H. P. Blandy, foundation president who announced the inauguration of the $275,000 research program, the four studies become of "great significance in providing comprehensive, systematic, nationwide facts necessary to meet the health needs of the American people."

When completed, it is anticipated that the studies will result in the accumulation of many essential facts on the accomplishments of voluntary health insurance. From the viewpoint of hospitals, Blue Cross plans and all others concerned with improving and extending on a wider basis the benefits of voluntary health insurance, the studies will undoubtedly offer positive direction for determining how voluntary health insurance can be further developed to help meet the nation's health needs. The Health Information Foundation deserves fully the help and cooperation of all who want to extend more widely the values and benefits of voluntary health insurance.

Left hand, right hand

WHY IS A NONPROFIT hospital tax-exempt? The Bureau of Internal Revenue knows. But the Post Office Department does not.

This was made painfully evident recently when the Post Office ruled that nonprofit hospitals may not take advantage of the postal rate exemption which Congress allowed to "religious, educational, scientific, philanthropic, agricultural, labor, veterans' or fraternal organizations or associations, not organized for profit, and none of the net income of which inures to the benefit of any private stockholder or individual."

The Post Office Department generously admitted that nonprofit hospitals "often maintain free clinics or clinical service at a nominal fee; provide laboratory tests and examinations; and conduct training courses for physicians and nurses; thus, in part, being philanthropic, scientific, and educational, respectively." Then came the big *however:* "However, these functions are merely incidental to the institution's principal purpose, that of giving hospital care and treatment to patients, and for this service, charges are made and payment required in accordance with established rates and fees."

This in itself was a startling statement. But the real shocker came in a conference between representatives of the American Hospital Association and Post Office officials, when one of the latter commented: "We have all had experience with hospital service and have found nothing philanthropic about it."

That the situation is confused is evident. Somehow, some hospitals that have applied for exemption have been granted it. But others essentially similar in character and service have been refused.

Section 101(6) of the Internal Revenue Code exempts from federal income taxes "corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, literary, or education purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, and no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation."

Most states have similar statutes. And there are many federal and state court decisions which hold that the mere fact that a hospital accepts pay patients does not relieve it of its charitable status.

The Bureau of Internal Revenue recognizes that it is not necessary for exemption as charitable that an organization provide its services free of charge.

Space does not permit a dissertation here on the justification of tax exemption. This was set out in a statement by the president of the American

Hospital Association to the Ways and Means Committee of the House of Representatives in 1947, and a copy of this statement was sent to all institutional members as Washington Service Bureau Bulletin 76. Extra copies are available from the Washington Service Bureau.

Further, each state hospital association has a loose-leaf service on state legislation from the Washington Service Bureau, and this includes a section on the tax-exempt status of nonprofit hospitals.

Essentially, the tax exemption is granted in our society to encourage voluntary effort to perform necessary civic functions that would otherwise be a burden upon government. When the citizens of the community voluntarily contribute charitable funds to the establishment and maintenance of an institution that is open to the public for humanitarian service and which operates without the purpose of personal profit, then it is in the interest of society to encourage this voluntary effort. Further, since no personal profit is involved, any tax imposed must necessarily add to the cost of hospital care, and the tax in effect is a tax on sickness.

Community hospitals are rapidly expanding their services. They are becoming community health centers. It should not be too difficult to demonstrate the semi-civic functions of the nonprofit hospital and its eminent qualifications for the special encouragement of the traditional tax exemption.

While the higher postal rates will not add to hospital costs the way full taxation would, postage is still an important item. The administrator of one hospital conducting a fund drive estimates that the increased postal rates will cost his hospital $1,700 a year.

The American Hospital Association is still working on ways to secure this important exemption for nonprofit hospitals. In fact the Board of Trustees of the Association has authorized litigation against the Post Office Department to clarify the situation and cause the Post Office to recognize the long line of court decisions that favor hospitals in interpretations of laws with similar wording and intent.

This is the kind of activity that a single hospital could hardly conduct alone and is an example of group action—the kind of action that an association can carry on for all its members.

As strong as the weakest link

WHATEVER THE PHRASEOLOGY, all state hospital associations have the same objective as the American Hospital Association—"to promote the public welfare through the development of better hospital care for all the people." Thus, it should be a foregone conclusion that all hospital associations strive constantly to raise standards of care for hospital patients. It is, of course, quite obvious that the raising of standards requires time, effort and money. Such an objective cannot be realized in a relatively short period of time. There is overwhelming evidence on all sides in proof of the tremendous advances hospitals generally have made in improving patient care since the turn of the century. And there is certainly widespread agreement that much remains to be accomplished before the ultimate aim is realized.

One of the prime reasons why hospitals band together locally, statewide and nationally is to achieve this common goal. Through their local, state and national associations, hospitals cooperate wholeheartedly on programs and activities of mutual concern. Their only reason for doing so is to improve their service to patients and to the ultimate community.

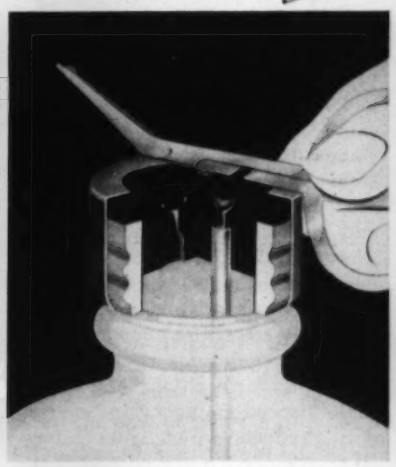
Since hospital associations are voluntary organizations, they can establish whatever membership requirements they see fit. When some hospitals cannot meet the minimum requirements for membership, failure cannot be placed on the particular hospital association. In setting minimum membership requirements, the association does not anticipate that hospitals which are accepted will not attempt diligently to advance beyond the minimum. On the contrary, experience has indicated that association membership provides added incentive to improve and advance toward higher goals. Experience has also shown that the minimum membership standards of any type of association, hospital or otherwise, are those of its weakest members. Because of the public service nature of hospitals, it is not the duty of the hospital association to lower its standards to meet those of the individual hospital; it is the responsibility of the hospital, which wants to participate in and benefit by association work, to meet the minimum standards established for membership.

The old adage that "the chain is only as strong as its weakest link" should be considered carefully by those who argue in favor of accepting substandard hospitals for membership. One step in the direction of lowering membership requirements can only lead inevitably to further backward steps. The great strides hospitals are making in providing more and better patient care will be lost by reducing the present minimum standards for association membership. Hospitals which have a part in such action do not "promote the public welfare through the development of better hospital care for all the people."

3 GREAT ADVANCES

IN I. V. THERAPY

Exclusive With CUTTER



Polysal*

A *single* solution to build electrolyte balance! Instead of unphysiological "physiological" saline, more and more doctors are specifying new Cutter Polysal because:

1. Polysal prevents and corrects hypopotassemia without danger of toxicity.
2. Polysal corrects moderate acidosis without inducing alkalosis.
3. Polysal replaces the electrolytes in extracellular fluid.
4. Polysal induces copious secretion of urine and salt.

Make sure *you* have stocks available . . . order Polysal now.

Saftitab* Stopper

Safer because it's solid yet with open-stopper convenience! Removable air and outlet tabs are integral parts of molded one-piece stopper. *In addition,* cap pressure forces base of tabs into ball sockets to form secondary safety seal (see left tab).

For convenience, molded-in tabs are quickly removed with bandage scissors. Once tabs are removed, the Saftitab Stopper has through holes for easy insertion of I. V. set.

Exclusive on *all* Cutter Saftiflask® Solutions and Saftisystem* Blood Bottles.

Safticlamp*

Precision control of fluid flow with just one hand! This revolutionary new plastic clamp won't slip, break or cut the tubing. Easily adjusts as often as desired without loss of precision.

The new Safticlamp is built into *every* Cutter expendable set at no extra cost; is where it's wanted, when it's needed; saves valuable time.

Another Cutter contribution to simplified routine. Cutter Laboratories, Berkeley, California.

*Cutter Trade Mark

You Can SIMPLIFY FOR SAFETY WITH Call CUTTER Now

What hospital food buyers should know about inspection services

EDWARD F. KELLY

THE ESTABLISHMENT, conduct, control and enforcement of food inspection services are matters of immediate concern to every American, whether he works with food or merely eats it. But food inspection is of special importance to all hospitals. Although it is believed that the United States has, perhaps, the finest food inspection services in the world, it can go only so far in protecting consumers.

Many institutions fail to avail themselves of these services. They also fail to supplement government inspections with their own inspections. Many institutions overlook the need for local inspections of food which has reached them days or weeks after it has left the scene of federal inspection and approval, and has passed through a number of hands, which may or may not have maintained proper standards of sanitation.

The general problems are (1) determining the meaning, scope and availability of food inspection services and (2) setting up the mechanics for employing these services to the maximum degree possible.

Federal surveys show that food inspection standards vary considerably with geographic areas, concentrations of population, remoteness of locations and militancy of local health officials. Also, the distribution and adequacy of inspection services are often based upon public demand. Food sanitation ordinances or codes, although officially adopted by communities or local governments, have little value unless they are adequately enforced.

It is difficult to give a complete picture of food inspection services as they exist throughout the country because the function is divided between five federal agencies or departments as well as the state and municipal ones, and also because the authorities, facilities, standards and procedures vary from area to area. Because the scope of the inspection activity and the standardization of food processing by the federal government are limited by law and not always mandatory, consumers must rely upon the support given to these regulations by state and municipal authorities. Also, federal inspection agencies govern only products which enter interstate commerce. Fortunately, these agencies do furnish advisory assistance upon request from consumers, even where compliance is not mandatory.

MEAT AND MEAT PRODUCTS

The Meat Inspection Service of the Bureau of Animal Industry (BAI), United States Department of Agriculture, is responsible for the inspection of meats. Their inspections and jurisdictions cover only meat and meat products handled or produced at packing houses doing interstate or foreign business.

It is the responsibility of the packing house to see that proper standards are employed by the distributors or vendors. Although state and city ordinances and controls in most areas are usually adequate for the purpose, there still may be danger if they are not being enforced. Hospitals should be on the alert to detect any evidence of uncleanliness, unwholesomeness or spoilage.

POULTRY AND EGGS

Unlike meat and meat products, poultry is not covered by federal law requiring that all interstate shipments be inspected and approved by federal inspectors. Many of the larger poultry and egg packing houses, however, because of their wide interstate operations and because the "U.S." stamp greatly increases the marketability of their products, voluntarily employ the inspection and grading services of the Production and Marketing Administration (PMA), which is charged with these functions. PMA's services are available to packers if their plants and operations meet the sanitation requirements of the Department of Agriculture. In addition to poultry and eggs, the PMA inspects and grades egg products such as frozen and dried eggs. (The PMA also may grade red meat products which have been inspected for purity by BAI.)

In most large cities, hospitals may engage PMA inspectors to inspect and grade food items, either at packing houses or on their own premises. Products turned out by processors who have availed themselves of PMA services are clearly identified with official stamps and marks. Because PMA inspection facilities exist at present in only 29 states, and because plants employing PMA inspectors do not necessarily do both poultry canning and eviscerating, hospitals should exercise caution in the procurement of these products, especially in the case of non-eviscerated or New York dressed poultry.

FRUITS AND VEGETABLES

Department of Agriculture inspections of fruits and vegetables represent a voluntary program which does not give their inspectors police authority. However, PMA inspectors do report bad sanitary practices to Food and Drug Administration (FDA), and work closely with the latter's in-

Mr. Kelly is chief, Standards and Requirements Section, Division of Administrative Management, Bureau of Medical Services, U.S. Public Health Service, Washington, D. C.

3 Great Baby Incubators

1 ARMSTRONG X-4 (Nursery Type) INCUBATOR

The original Armstrong baby incubator designed for safety, reliability, simplicity of operation, low operating cost and low initial cost. Experienced-perfected and hospital proven throughout the world. The X-4 was the first Baby Incubator ever to be tested and approved by Underwriters' Laboratories and is still the low-cost Baby Incubator of choice for general nursery use.

2 ARMSTRONG X-P (Explosion-proof) INCUBATOR

The FIRST explosion-proof baby incubator ever built and the FIRST to be tested and approved by Underwriters' Laboratories for use wherever explosive anesthetic gases create a hazardous atmosphere. SAFE in the delivery room. SAFE in the surgery. SAFE for aseptic transportation of infants from delivery room to nursery.

3 ARMSTRONG HAND-HOLE (De Luxe Model) INCUBATOR

Truly a de luxe baby incubator but designed to sell for about one-half the cost of other high-priced, hand-hole incubators. Thick, steel-reinforced, transparent Lucite sides. Safety glass top. No distortion. Each equipped with new, simple nebulizer at no extra cost. 4 hand-holes, and a large opening for administering parenteral fluids. Oxygen control provides BOTH high and low concentrations. A bigger incubator for the larger term baby and for the critically small premature.

Write for complete details on any or all of these 3 Armstrong Baby Incubators.

THE GORDON ARMSTRONG COMPANY, INC.

Division LL-1 Bulkley Building, Cleveland 15, Ohio

Distributed in Canada by Ingram & Bell, Ltd.

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BACK OF EVERY ARMSTRONG BABY INCUBATOR IS OVER 17,000 INCUBATORS' WORTH OF EXPERIENCE. SINCE 1943 THE SELLING PRICE TO YOU OF ARMSTRONG BABY INCUBATORS HAS BEEN INCREASED LESS THAN 3½%.

spectors. Because most fruits and vegetables are shipped across state lines to market, the FDA takes a strong hand in their inspection and testing, especially where they have previously found trouble or complaints. In connection with fruits and vegetables, PMA makes inspections of both fresh and processed items. The Processed Products, Standardization and Inspection Division of PMA, takes over where the Fresh Products Inspection Service leaves off.

Although PMA reports that their inspections cover a majority of fruits and vegetables produced for big markets, especially those handled by large corporations, they nevertheless advise that hospitals wishing to be sure of PMA inspections should insist, wherever possible, that products bear the stamp or label, "Packed Under the Continuous Inspection of the U.S.D.A." Hospitals may obtain information or answers to their questions concerning fruits and vegetables by contacting the nearest office of the appropriate PMA activity. No charge is made for this service unless it includes a requested visit to the hospital or the vendor for inspecting or testing products.

Because the PMA will "downgrade" any produce which shows evidence of harmful spray substance, and because this will lower its marketability, growers and packers make special efforts to overcome this danger. Also, the FDA is constantly alert to harmful spray materials by routinely and seasonally testing spray substances, checking spray schedules followed by growers and inspecting and testing for residual material.

MILK AND DAIRY PRODUCTS

The Milk Ordinance recommended by the Division of Sanitation, U.S. Public Health Service (PHS-DS), is "an ordinance to regulate the production, transportation, processing, handling, sampling, examination, grading, labeling, regrading and sale of milk and milk products; the inspection of dairy herds, dairies and milk plants; the issuing and revocation of permits to milk producers and distributors; the placarding of restaurants and other establishments serving milk or milk products; and the fixing of penalties." The related Public Health Service Milk Code is used for the legal interpretation of the milk ordinance, and includes definitions and meanings of the terms and provisions of the ordinance. Wherever adopted and enforced, the milk ordinance provides safe, adequate public health standards in the field of milk production, processing and handling. Because the milk ordinance is not mandatory upon milk producers unless it has been adopted by state or local authorities, and because its adoption does not necessarily imply that it is being enforced, the federal standards provided by the ordinance may or may not be followed in a given locality.

It is essential that hospitals in questionable areas insist that their milk conform to Type II, pasteurized milk No. 2 of the Federal Specification—"Milk, Whole, Fresh —C-M-38le" (available from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.). Insistence on this minimum standard will help to guarantee the procurement of good, safe milk whether the milk ordinance is being followed and enforced or not. If any local, potential milk sources have not been approved, efforts should be made to have them inspected and approved before they are solicited for contract. Where it is impractical for a hospital's milk supplier to receive adequate, periodic inspection and there is some doubt as to the safety of the product, the hospital should make routine bacteria counts of the milk if laboratory facilities and personnel are available. In the case of dairy products, attempts should be made to obtain butter, cheese, dry milk and ice cream which have been inspected and graded by PMA.

SHELLFISH

There is little danger of hospitals receiving contaminated shellfish because practically all of the shuckers, packers and shippers in the industry are continuously inspected and approved by the state shellfish control authorities under the general guidance of the PHS-DS. The shellfish branch of this division publishes bi-weekly lists of certified shippers of raw oysters, clams and mussels, and hospitals will be sent copies of these lists upon request. Danger of getting contaminated shellfish lies chiefly in buying products which have escaped the federal-state system of certification. At present, most sources of noncertified shellfish are those vendors in inland cities who receive bulk shipments from seacoast areas for repacking. The sanitation standards of these local markets may be lower than those maintained at sources of production. However, hospitals should make sure they are protected by buying only certified shellfish packed in containers which bear the approval certificate number and the name of the state where inspection occurred.

FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration covers all foods and food products except sheep, swine, cattle and goats (which are controlled by the BAI), and if any question of purity or sanitation arises after products leave the area of jurisdiction governed by the other inspection agencies, the FDA may be called upon to handle the matter. FDA is charged with the enforcement of the Food, Drug and Cosmetic Act, the Tea Act, the Import Milk Act, the Filled Milk Act and the Caustic Poison Act. Although FDA is concerned only with products entering interstate commerce, the bureau may be called upon to make inspections of any products, including purely local ones, upon request. FDA has its own standards for food and its inspection and acceptance. It maintains 16 laboratories throughout the country and makes inspections or analyses on a project basis, not routinely but whenever there is some question or complaint regarding purity, sanitation or misrepresentation. However, regular, seasonal inspections of selected classes of products are made in all

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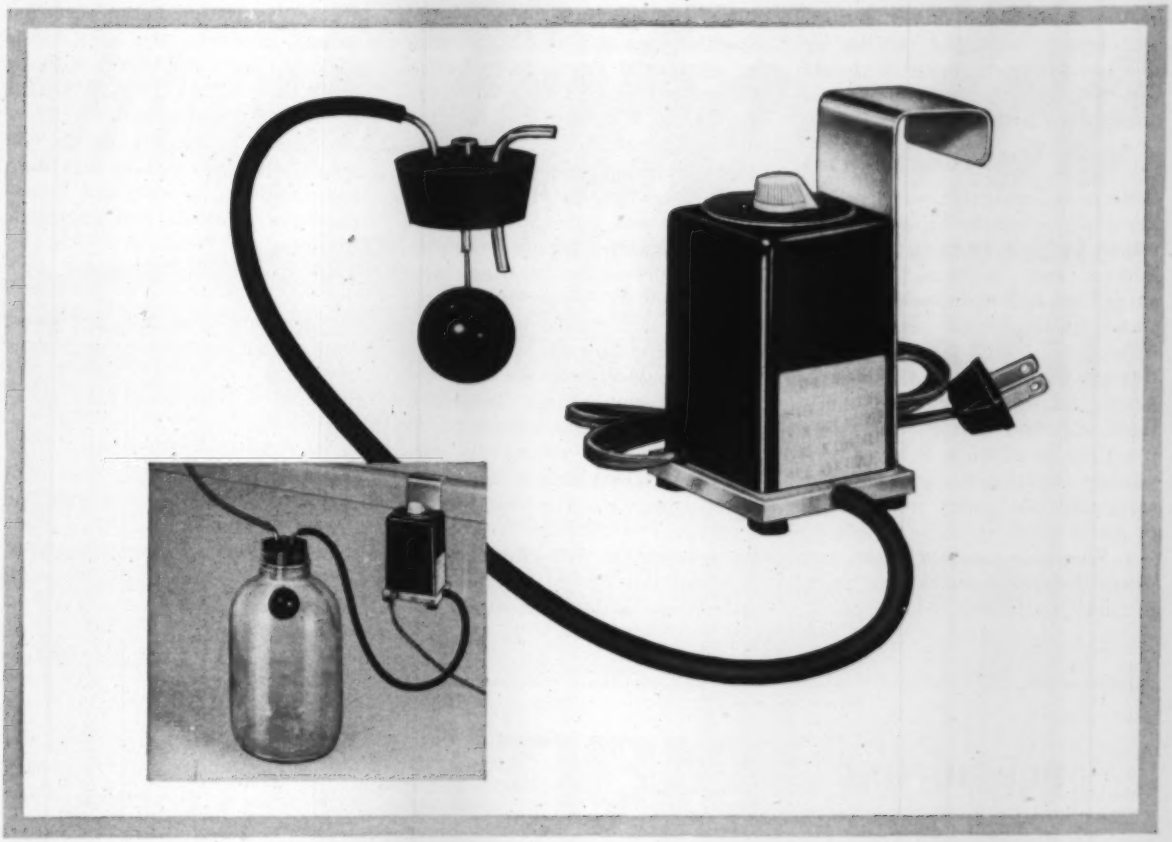
The Purchasing department is edited by Leonard P. Goudy, purchasing specialist.



Sensational New Aloe Vacuum Pump

Provides continuous, mild suction for drainage and aspirating technics - only **$29.50**

This efficient new vacuum pump has all the power necessary for mild drainage and aspiration, yet the power unit itself occupies only 2½ inches of space, and is offered at a fraction of the cost of conventional pumps. Dial control makes possible variable vacuum from 2 to 15 inches; air displacement up to 600 cubic centimeters per minute. Supplied complete with special float which fits ½- or 1-gallon Mason type jars. The unit is sealed in a black case mounted on machined aluminum base. Base mounted on sponge rubber feet — will not "crawl." An aluminum bracket is supplied to attach pump unit to bed rail. Unconditionally guaranteed for one year.

JB906—Aloe Vacuum Pump, for operation on 110-120 volts, 60 cycle, A.C. only. With safety float, tubing, cord and plug; only.... **$29.50**

Bottle Holder keeps drainage bottle safe from accidents.

Aloe Out-O-Way Drainage Bottle Holder

Recommended for use with Aloe Vacuum Pump listed above. Eliminates accidents with drainage bottle; fastens to angle iron of bed by means of adjustable catch. Holds gallon Mason jars, Fowler bottles, or hospital food jars.

JS3507—Aloe Out-O-Way Drainage Bottle Holder,

as described, each	$ 5.00
In lots of 6, each	4.50
Per dozen	50.00

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LOS ANGELES 15, 1150 S. Flower St. • SAN FRANCISCO 5, 500 Howard St. • NEW ORLEANS 12, 1425 Tulane Ave. • MINNEAPOLIS 4, 927 Portland Ave. • KANSAS CITY 2, 4128 Broadway • ATLANTA 3, 492 Peachtree St., N. E. • WASHINGTON, D. C. 5, 1501 14th St., N. W.

of the states. FDA investigations deal largely with the identity or composition and purity of products and any factors which are harmful to health.

RECOMMENDATIONS

Because inspection services are generally available to, and maintained by, most leading food producers and packers, hospitals should not find it difficult to locate these concerns and obtain their inspection benefits through a carefully managed procurement program. Administrators and dietitians will find that the following practices, in addition to those previously mentioned, will help to safeguard the purity and quality of foods used by their hospitals:

1. Wherever possible, make pertinent federal specifications apply to bid invitations or contracts. (The annual "Index of Federal Specifications and Standards" may be purchased from the Superintendent of Documents, Washington 25, D. C. This index lists the name, number and cost of all current federal specifications.) If the total specification for any item cannot be met, bids should include the applicable "general requirements" provisions dealing with BAI, PMA, FDA, or PHS-DS inspections and standards.

2. Solicit contracts or purchase from only those vendors approved by U.S. government inspection agencies or federal consumers or from those who voluntarily employ the highest standards and inspection services available to your locality. The purchase of food in good condition will eliminate the financial loss caused by spoilage.

3. When in doubt as to the degree of sanitation being accorded certain products you buy, visit packing plants and confer with, or write to, the BAI, PMA, PHS-DS and FDA representatives. They are usually able to furnish the public with information regarding the handling, packing and transportation methods and standards employed by vendors.

4. See that those charged with the responsibility for food service equip themselves with adequate information pertaining to inspections and standards of purity and ways of guaranteeing that deliveries comply with these. The Superintendent of Documents, U.S. Government Printing Office, will furnish upon request a list and the prices of government publications which deal with these subjects.

Be sure of your food and you'll be sure of health.

PURCHASING COMMENT

Adapting anesthesia equipment

The deadline for adapting anesthesia equipment for the new pin-index safety plan is rapidly approaching. Hospitals should begin checking now with their medical gas suppliers to set up a schedule for converting their anesthesia machines.

As of August 1, 1952, manufacturers began drilling cylinder valve stocks (2P-2).* January 1, 1953, was the last date when undrilled cylinders were to be shipped by suppliers. If the hospital's supplier is shipping undrilled cylinders, that matter should be brought to his attention.

The hospital also should make certain now that any remaining undrilled cylinders are returned to the supplier.

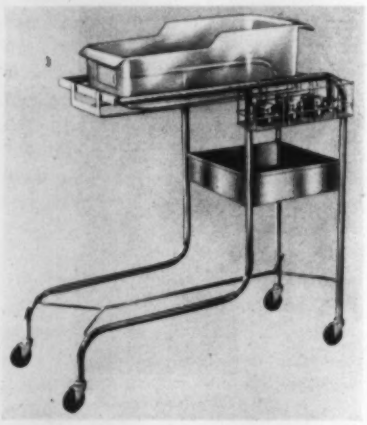
On May 1, manufacturers will begin to adapt anesthesia machines in the hospital for the new system. After conversion, it will be impossible to use undrilled cylinders.

A complete report on the pin-index system can be found beginning on page 84 of the August 1951 issue of HOSPITALS. Those hospitals not having a copy of that issue may write the Editorial Department, 18 East Division Street, Chicago 10, for a free reprint of the report. It describes in detail the system adopted jointly by the Compressed Gas Association, the American Hospital Association and the American Society of Anesthesiologists for avoiding errors in medical gas administration.

Stainless steel bassinet

A bassinet designed to serve either rooming-in technique or cubicle nursery arrangement with maximum safety and facility has been developed (2P-1).* Lightweight construction and rubber-tired swivel casters aid mobility of the stainless steel model. The unit is equipped with an extra long extension base which slides under the bed, bringing all necessary supplies within convenient reach of the mother. For cubicle arrangement in the nursery, the bassinet contains all necessary equipment for individual attention.

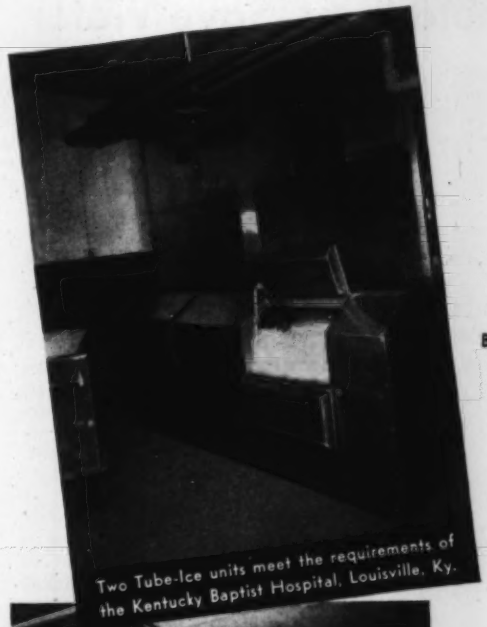
The basket is made of lightweight plastic, and can be removed or tilted at either end. The utensil holder is portable and can be attached to either end of the stand. The shielded shelf is welded to the uprights for durability. The unit contains no painted surfaces and no dirt-collecting joints or crevices.



*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 East Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

Modern Tube-Ice*

Enjoys the Acceptance of Many of America's FINEST HOSPITALS



Two Tube-Ice units meet the requirements of the Kentucky Baptist Hospital, Louisville, Ky.

Installation of a 2000 pounds per day capacity Tube-Ice Machine at Watts Hospital, Durham, N.C.

The Good Samaritan Hospital, West Palm Beach, Florida, is served by this Tube-Ice unit.

The McLeod Infirmary
Florence, South Carolina

Our Lady of Peace Hospital
Louisville, Kentucky

Cleveland City Hospital
Cleveland, Ohio

Southwestern State Hospital
Marion, Virginia

Englewood Hospital
Englewood, New Jersey

Norton Memorial Infirmary
Louisville, Kentucky

Rochester General Hospital
Rochester, New York

Vanderbilt University Hospital
Nashville, Tennessee

U. S. Naval Hospital
Camp Jos. Pendleton, Oceanside, Cal.

Otisville Municipal Sanatorium
Otisville, New York

University of North Carolina Hospital
Chapel Hill, North Carolina

*Tube-Ice, produced by the Vogt Automatic Tube-Ice Machine, is a clear, hard ice of superior quality. Either cylinder or crushed ice may be had from the same unit at the flick of a switch! Units are available in sizes from 2000 pounds per day up to any desired capacity.

HENRY VOGT MACHINE CO., LOUISVILLE 10, KY.
BRANCH OFFICES: New York, Philadelphia, Chicago, Cleveland St. Louis, Dallas, Charleston, W. Va.

Vogt Automatic TUBE-ICE MACHINE

CRANE DIAL-ESE FAUCET CONTROLS

Reduce maintenance costs and shutdowns. Save Water

Dial-ese controls—now on all Crane hospital fixtures—are one of the most important plumbing developments in years. Here's what they do for you:

Save water because they close with the water pressure (ordinary faucets close against pressure). Force of water itself actually aids in making water-tight closure. Minimize waste of water that costs you money to heat.

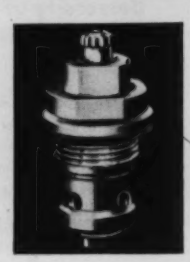
Make maintenance easy because all wear-subjected parts are enclosed in single replaceable unit called a "cartridge." Same unit fits all Crane faucets and makes maintenance a simple, uniform procedure.

Reduce shut-down time because any cartridge can be replaced by new one in seconds. No need for fixture to be out of service while maintenance man makes lengthy repairs.

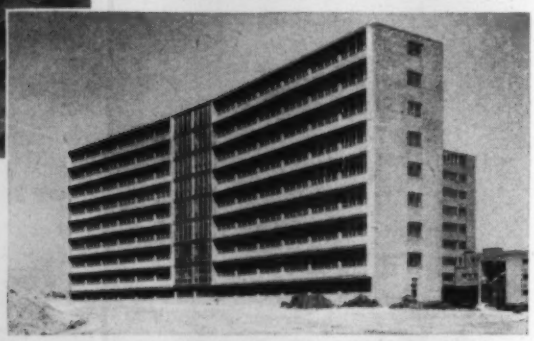
Stand up longer because stem threads operate in sealed lubricated chamber and stem packing is below threads—no liming or corrosion.

Dial-ese controls are but one of many advantages you gain with Crane specialized hospital fixtures. Get full facts from your Crane Hospital Catalog—or from your Crane Branch, Crane Wholesaler or Plumbing Contractor.

Patient's Bath. One of many Crane specialized hospital fixtures in the new Northville State Hospital, Northville, Michigan. Made of Crane's exclusive all-ceramic Duraclay, this fixture resists acids, hard knocks, hard usage. Equipped with Dial-ese controls.



Dial-ese Cartridge. This simple unit contains all wear-subjected parts of Crane's exclusive Dial-ese faucet control. Can be slipped out of faucet and replaced in seconds. Saves maintenance time.



Crane-equipped Northville State Hospital is a good example of modern hospital construction. Designed by architects O'Dell, Hewlett & Luckenbach, Detroit, Michigan. General contractor: O. W. Burke, Detroit, Michigan. Plumbing contractor: Drake Avery Company, Detroit, Michigan.

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VALVES • FITTINGS • PIPE
PLUMBING AND HEATING

The engineer's role in purchasing discussed in Association manual

THE IMPORTANCE of the engineering and maintenance department in today's complex unit, the hospital, is underlined in the new *Manual of Hospital Maintenance,* published recently by the American Hospital Association. The job of supervising this department is customarily assigned to a specialist, a man thoroughly familiar with the equipment, who appreciates the tremendous investment it represents and understands how important it is to get efficient and uninterrupted performance from it. A large part of his job, other than the maintenance and repair of the equipment, is his role in the purchasing of fuel, supplies, tools and equipment.

It is understood that the engineer should specify quality and quantity of all purchases for his department. He should be consulted before purchasing equipment for other departments if his department is to be responsible for the installation, operation or maintenance. The advisability of purchasing replacement parts from the original manufacturer of the equipment calls for such consultation.

FUEL PURCHASING

Fuel for steam generating is a major item in any hospital budget and great care should be exercised in determining the proper type of fuel to be used.

When the engineer has determined the best available fuel for his plant he should draw up detailed specifications describing the particular fuel required, and the quantity for each month of the year. Consideration must be given to the available space for storing fuel (either coal or oil) and in localities where winter storms may isolate the hospital from usual sources of fuel supply, the storage capacity should be sufficient to carry the plant for 10 or 15 days at peak load.

The purchasing agent should get competitive bids from three or more suppliers if possible, using the specifications prepared by the engineer. The purchase of electric power, gas and water is simplified, since there is usually only one source of supply with rates established by public utility commissions.

Because hospitals usually produce high-pressure steam, operation of electrical generating equipment is occasionally considered where public utility rates are comparatively high. In determining the advisability of operating generators, the cost of maintaining stand-by connections with the local electrical company should be included in cost computations.

STANDARDIZATION

Inventories may be substantially reduced if equipment and supplies are standardized. For instance, if all electric motors are of the same manufacture, the variety of spare parts in inventory is determined chiefly by the number of different sizes of motors in use, since any spare part will fit any motor of the same size and frame. The introduction of several different makes of motors increases the inventory by requiring spare parts for each make, type and horsepower. When purchasing new equipment, the manufacturer of the motor elements should be specified in order to maintain the desired uniformity of equipment.

Repair expenses are reduced and flexibility of equipment is increased by standardization of equipment and supplies. Complete spare units may be substituted for defective units, thus rapidly restoring service, but allowing the defective unit to be repaired when convenient and with the advantages of the shop facilities.

ENGINEERING SUPPLIES

All major items of engineering equipment such as pumps, compressors, motors, steam generators, paint, hardware and electrical equipment should be specified by the chief engineer as to size, type, capacity, electrical characteristics, color and similar requirements. The manufacturer should be specified only if there is an advantage in obtaining the equipment from one particular source of supply or in the interest of standardization of equipment and supplies.

Day-to-day items of normal use such as pipe, pipe fittings, electric conduit, wire, lamps and similar material should be requisitioned through the purchasing department in amounts sufficient to provide 3 to 6 months supply; thus the purchasing agent can get competitive prices on large quantities and purchase advantageously.

It is often necessary to purchase certain supplies on a contractual basis. Such items as painting, construction work, fuel, lubricating oils and greases and gasoline are frequently bought on contract.

In such a case, the engineer should prepare a detailed specification of the scope of the work to be done or the materials to be furnished. Competitive bids from three or more contractors should be received and the contract awarded to the lowest *responsible* bidder. The preparation of the specifications, production of necessary plans and analysis of bids is usually done under the direction of the engineer. The contract is awarded according to established policy after consultation with the engineer and the administrator, who in some hospital organiza-

This article is adapted from the "Manual of Hospital Maintenance," American Hospital Association, Chicago.

tions also must secure approval from the governing body.

RESPONSIBILITIES

The engineer should examine all plans, specifications and proposals and be given opportunity to make recommendations concerning them before they are sent out for bids. When the work is in progress he should make at least daily inspection of the work being done to assure that proper materials and workmanship are being provided and that all terms of the contract are being followed.

The engineer should provide the contractor with information relative to the location of all pipes, conduits, ducts and the like, which may interfere with the progress of the job. We should also arrange for all necessary interruptions of hospital utility services when new connections are to be made. It is customary for him to make periodic reports to the administrator on the progress of the work.

It is essential that a satisfactory system be provided for preserving and cataloging manufacturers' lists, maintenance instructions, parts lists and blueprints.

Blueprints should be hung up or laid flat (never rolled) in steel cabinets. The other material should be filed in ordinary filing cabinets.

On completion of a new building or major addition to the hospital plant the engineer should receive several copies of a list of contractors and suppliers of materials and equipment used in the new construction. The list is usually arranged alphabetically according to the individual items used in the construction and a notation made as to who furnished the item—blinds, bricks, blackboards, blower, boiler and the like—with the supplier's name and address indicated for each item. This list will prove most valuable when it is necessary to purchase identical equipment for replacement or additions.

When purchasing any new mechanical, electrical, heating, ventilating or refrigerating equipment, the purchase order should require the supplier to furnish three copies of descriptive literature on installation, operations, maintenance, and repair, including a parts list for the unit on order. One set should be filed in the engineer's office and two sets in the office of the foreman responsible for the maintenance of the particular equipment. The engineer's set should never leave his office, but one set in the foreman's office may be removed from the files and used by workmen while making adjustments and repairs.

All blueprints of grounds, buildings, systems, and the like should be preserved in metal cabinets in the office of the engineer. It is well to require "as built" record tracings of all new major construction, showing deviations from contract plans.

INVENTORY

The engineer is responsible for the continuous operation of the physical plant of the hospital, the constant availability of utility services, and the maintenance of emergency medical equipment. To assure this continuous service and availability of equipment it is necessary to maintain a proper inventory of spare parts and supplies so as to be self-sufficient.

The size of the inventory is determined by the relative location of the hospital to the usual source of supply; hospitals in metropolitan areas usually have many sources of supply and therefore carry relatively low inventories.

Discarded equipment should be carefully surveyed and if not reasonably sure of prompt re-use, it should be stripped of usable spare parts and the remainder junked. Valuable storage space in most hospitals contains far too much equipment which will never be used again.

There should be a suitable assortment of engineering tools and equipment for doing routine and emergency work. In addition to the usual hand and shop tools there may be chain hoists, jacks, gasoline driven pumps, welding equipment and power tools.

Ideally, all engineering supplies, tools and equipment should be stored separately from the general hospital stores and preferably convenient to the engineering shops. Purchased materials are received by an administrative employee who handles the book work.

Before the goods are placed on racks or shelves prepared to receive them, they should be checked by a maintenance employee. Materials should be issued on order to the engineering department, on a job order number or for shop use. The clerk automatically requisitions materials when the stock reaches a predetermined minimum established by experience.

Tools for special use, such as electric drills and hammers and portable sump pumps may be issued to workmen by the maintenance clerk or the engineer, so that a record may be kept of who is using the tools and of their condition on return.

Small items should be stored on shelves or in bins, pipe placed on racks, and lumber suitably supported on edge.

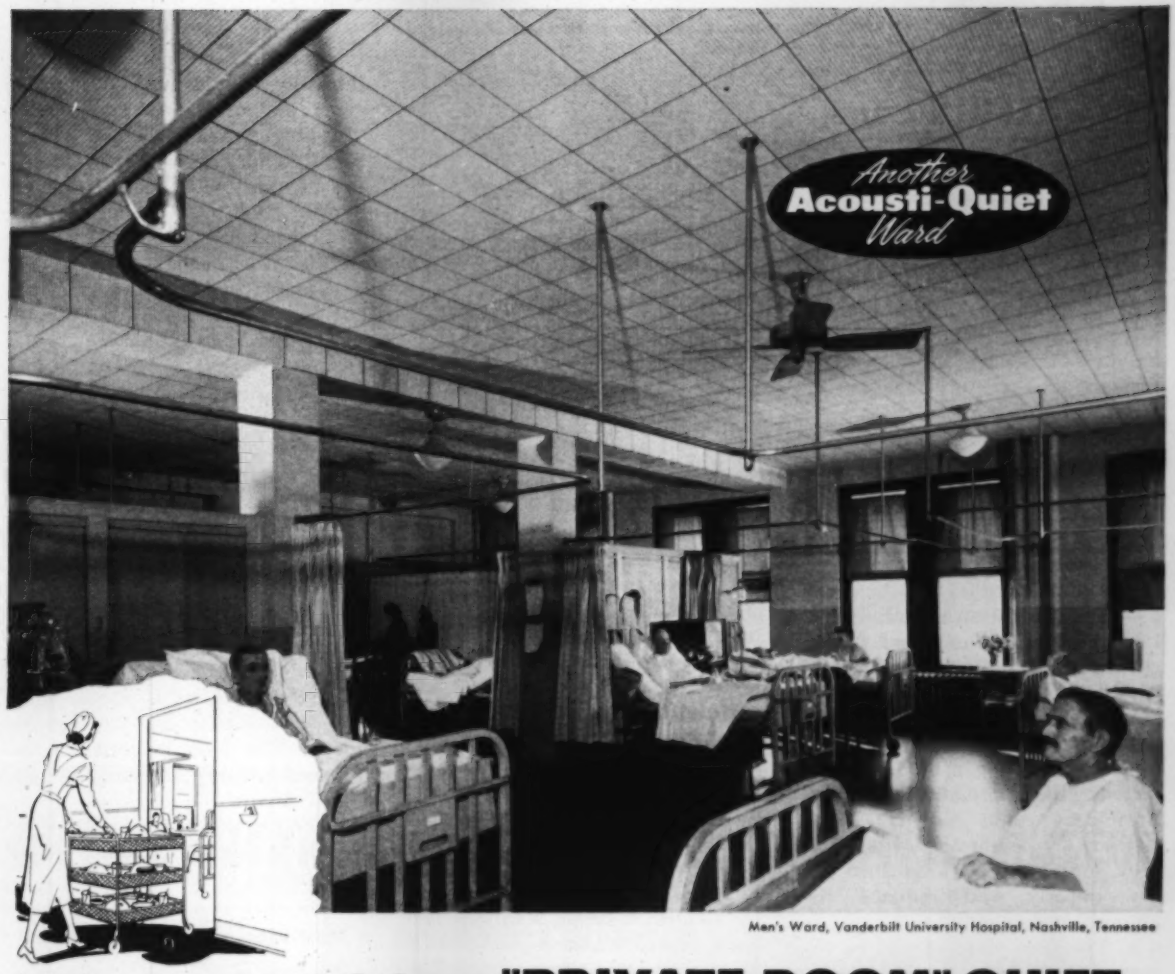
Tools may be kept in cabinets for their protection and ease of checking for loss. It is advisable to establish a locked cabinet containing all tools necessary for emergency work at night. These tools should be identified by a distinguishing color and used only for emergencies.

STORAGE

Rooms, cabinets and outside buildings for the storage of flammable liquids are recommended in detail in NFPA Standard No. 30-C of National Fire Codes, Volume 1, which is published by the National Fire Prevention Association, Boston, Mass.

Storage rooms for alcohol, ether and volatile solvents, such as benzine, should not be a part of the hospital building, but when so established should be above grade and conform to standards of design and ventilation.

In establishing policies for the purchase of materials used by the engineering department it is necessary to establish the working relationship between the engineer and the purchasing agent. Assuming that each is competent in his own field, it is to the best interest of the hospital (and certainly a great saving of the engineer's time) to require that all purchases, except those necessary in case of emergency, be made by the purchasing agent.



Men's Ward, Vanderbilt University Hospital, Nashville, Tennessee

Now, even wards have "PRIVATE ROOM" QUIET

With people walking and talking, equipment being moved, trays and dishes clattering—wards can be a noisy headache. But as hundreds of hospitals have discovered, routine noise need not be allowed to rob ward patients of the relaxing quiet they need for convalescence. It can be controlled . . . effectively and economically!

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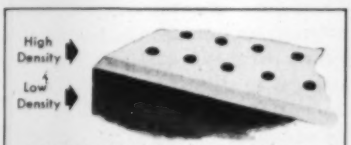
Acousti-Celotex Sound Conditioning is the answer. A sound-absorbing ceiling of Acousti-Celotex Tile checks noise in wards, operating and delivery rooms, nurseries, private rooms, corridors, lobbies, kitchens, utility rooms. It brings *soothing quiet* that helps patients rest and relax, and enables hospital personnel to work more efficiently.



DOUBLE-DENSITY—As the diagram shows, Acousti-Celotex Tile has two densities. *High density* face, for a more attractive finish of superior washability, easy paintability. *Low density* through remainder of tile, for greater sound-absorption value.

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ENGINEERING and MAINTENANCE COMMENT

Storing sodium chlorate

THE FEDERAL Security Agency recently released a report after an investigating committee had probed into an explosion and fire of a chemical-loaded (sodium chlorate in pasteboard cartons) hand truck in a university chemical laboratory.

The recommendation section of the report was of interest and read:

1. Sodium chlorate should never be stored in a general storage area.

2. Sodium chlorate for laboratory use should be in glass bottles containing not over one pound. Stocks should be limited to immediate needs.

3. Storage spaces of this size (about 1,470 square feet) without means of venting should be protected with automatic sprinklers. Sprinklers could not have prevented the violent combustion but they would have extinguished the fire quickly and reduced the amount of damage.

4. The door stops should be removed from all stairway doors. The closers should be put in working order and strict instructions should be given and enforced that all stairway doors are to be closed except for the momentary passage of personnel.

Tests of floor coverings

The National Bureau of Standards reported last year upon the results of tests made by 17 different manufacturers on 40 types of floor coverings for their resistance to grease, oils, alkalies, acids, and bleaches. The tests included such general types of flooring as vinyl, rubber, linoleum, asphalt, and printed enamel. The floors were exposed for 24 hours to each of the following: beef tallow, kerosene, cottonseed oil, lubricating oil, solutions of soap, sodium carbonate, trisodium phosphate, sodium hydroxide, acetic acid, sulfuric acid, and hydrogen peroxide.

The softening effect of these products on the floor coverings was checked with a Taber Abraser specially adapted for measuring the decrease in resistance to penetration. These were the results of the tests:

Vinyl—In general, the vinyl plastic floor materials were the most resistant to grease and oil and with few exceptions showed fairly good resistance to alkalies. Several of the plastic samples were adversely affected by dilute acids. From an over-all point of view, the vinyl plastic flooring possessed the best properties for use in locations subjected to frequent exposures of grease, oils, and alkalies.

Asphalt—This tile showed very poor resistance to most oils and only fair resistance to beef tallow. The so-called "grease resistant" asphalt tiles were not outstanding in their resistance to grease and oil and most of them showed poor resistance to dilute acids.

Linoleum—All of the linoleum samples were materially affected by alkaline cleaning solutions and were partially disintegrated by a 1 per cent solution of sodium hydroxide. They showed poor resistance to acids and hydrogen peroxide and with the exception of a brown battleship linoleum were softened by kerosene. Even beef tallow softened some of them.

Rubber—Rubber tiles were softened by kerosene but were resistant to beef tallow. The resistance to dilute acids and alkalies varied from good to poor.

Enameled print—The printed enamel felt base coverings, in general, were damaged by alkaline cleaners, dilute acids and kerosene.

Other proprietary floor coverings—Coverings having a resin composition wearing surface were fairly good in their resistance to oils and reagents, with the exception of kerosene and dilute acids. A cork composition flooring showed fairly good resistance to various oils and reagents but stood up poorly when exposed to sodium hydroxide.

Although vinyl tile was found, in general, to be more durable, it probably should not be laid on concrete floors that are in contact with the ground unless a waterproof membrane has been laid under the concrete floor. The only flooring that can be successfully laid on concrete subjected to damp conditions is asphalt tile.

(This report is reprinted from the May, 1952, Vol. X. No. 5 issue of Bureau News, published by the Hospital Bureau of Standards and Supplies, Inc., 247 Park Ave., New York 17.)

Automatic door control

Production of an automatic control which opens any type of door the instant a person steps on the carpet leading through the doorway has been announced (E2-1)*.

The control system consists mainly of the door control mechanism, which is concealed in the floor and the hydraulic power unit, equipped with a half-horsepower motor. The electric cord can be plugged into any standard 110 volt, A. C. circuit.

In case of power failure, the door is said to operate manually without locking or jamming.

Maintenance calendar of annual tasks

MIDWINTER

1. Check all portable electrical equipment.
2. Replace all worn appliance cords.
3. Check grounding wires for heavy, portable electrical equipment.
4. Check electrical circuits for overloading and over-fusing.
5. Overhaul laundry equipment.
6. Re-evaluate opportunities for extension of preventive maintenance program.
7. Check routine tests on fuel quality.
8. Cut out dead trees.

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

To provide greater comfort and safety for patients, the Community Health Center, Coldwater, Mich., has been completely equipped with Rusco Self-Storing Combination Windows.

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Specify: THE RUSCO PRIME WINDOW

A completely pre-assembled window unit containing glass, screen, weatherstripping, insulating sash (optional) and wood or metal surround. Comes fully assembled, factory-painted, ready to install. Makes big savings in time and labor.

FOR MODERNIZING EXISTING BUILDINGS

Specify: RUSCO SELF-STORING COMBINATION WINDOWS

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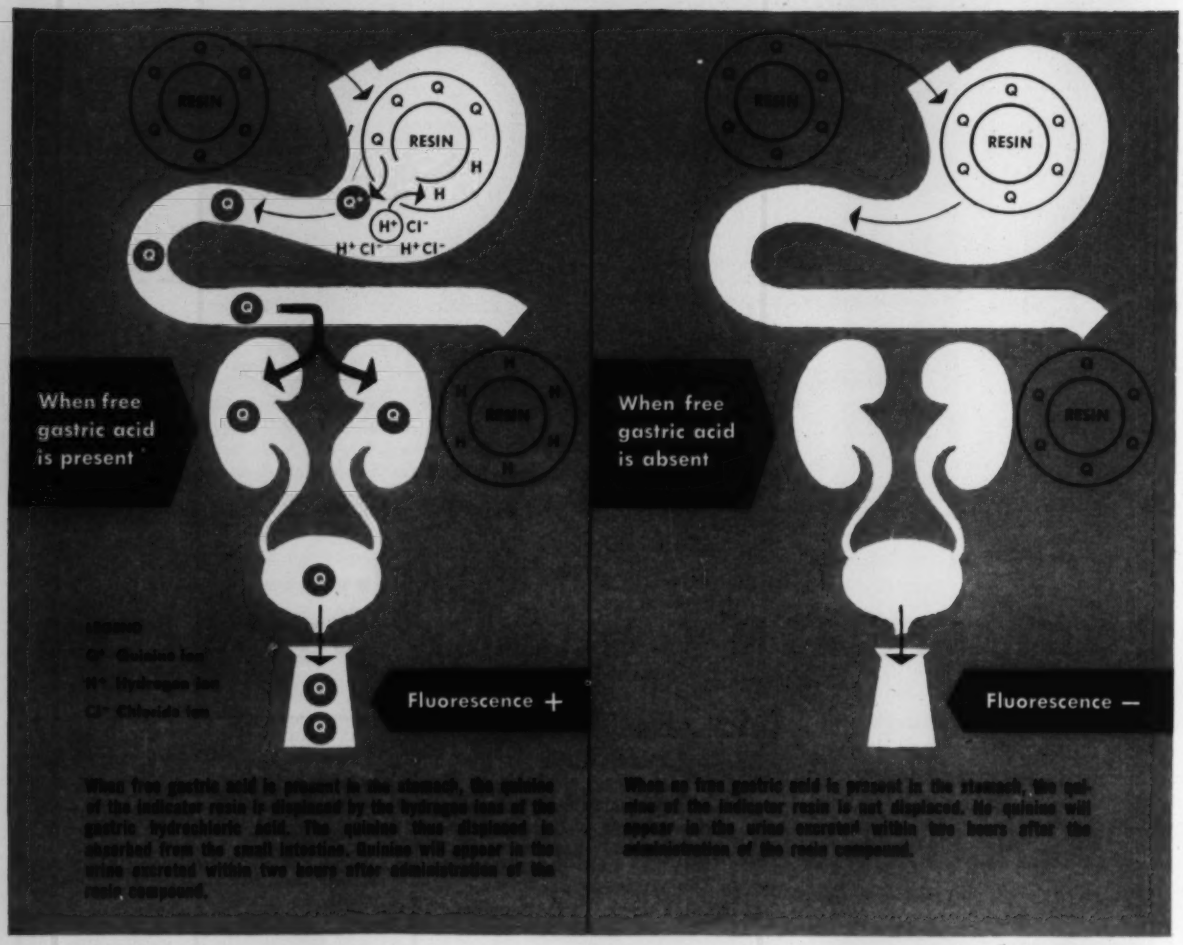
a test for achlorhydria

...without intubation



With the development of DIAGNEX, it is now possible to determine gastric anacidity without the inconvenience and discomfort of intubation. This new diagnostic agent is a quininium indicator resin which by cation exchange reveals the presence or absence of gastric hydrochloric acid through the presence or absence of quinine in the urine. Although the results of the test will not alone establish a final diagnosis, a finding of achlorhydria with DIAGNEX suggests the possibility of gastric cancer or pernicious anemia and will indicate the necessity of further study.

DIAGNEX is supplied as a match-folder type unit with separate foil packets containing the quinine resin for the test and a caffeine sodium benzoate capsule to stimulate gastric secretions. Three labels for urine collection bottles and complete directions for the patient are also included. Boxes of 10.

For further information on DIAGNEX, see your Squibb Professional Service Representative or write direct to E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, N. Y.

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SQUIBB QUININE CARBACRYLIC RESIN

Controlling unpleasant odors among mental patients

L. J. LEVANN, M.D.

AN UNPLEASANT odor invariably accompanies chronic or low-grade patients in mental hospitals and institutions for mental defectives. Until recently we accepted the situation as inevitable and hoped only to cover up the odor to some extent. We could not cover up, however, the high turnover among our employees which resulted from this aspect of working in a mental institution.

The recruitment and retention of personnel to care for patients is one of the major administrative problems confronting mental hospitals today. A significant proportion of employees drop out after a relatively short time. They cannot stand the smell that permeates the rooms these patients occupy.

Our nurses and attendants had been carefully screened and considerable selectivity had been exercised prior to employment. Yet when they were rotated to the low-grade wards there was a marked increase of psychosomatic complaints—lack of appetite, headache and nausea—as well as lateness and often absenteeism. Resignations usually came soon after these symptoms.

When nurses and attendants were interviewed after turning in resignations the reasons given by them were surprisingly limited. There was a paraphrasing of the following themes: "I can't stand the smell," "I start feeling sick as soon as I open the door," and "The smell from the low-grade patients is so bad I can't eat without feeling sick."

Dr. le Vann is medical superintendent, Provincial Training School, Red Deer, Alberta, Can.

That we would have to reduce the odor, if we were to retain employees, was apparent. We decided to experiment with the internal administration of chlorophyll.

Our first procedure in combating odor was to consolidate low-grade patients. An infirmary villa was established for bed-ridden patients in another ward. This had the immediate effect of concentrating, but localizing, the unpleasant aroma to two wards.

During the summer months the reduction of odor in wards was made considerably easier by screening and leaving open all windows and doors. Our mechanical ward ventilation system, adequate for higher grade wards, was inadequate for the colder months of the year when windows and doors are protected by storm windows and doors.

Previous experience with several types of ozone-producing apparatus, wick-evaporation type deodorants and pressure sprays had proved unsatisfactory. Indeed, after a short while, some of the personnel reacted adversely to the sprays, becoming more smell-conscious than they had been previously. One charge attendant summed up the general reaction when he said, "You know doctor, I don't like these things at all. I feel I'm working in a high-class lavatory all the time these things are released." The effectiveness of the sprays was generally less than 20 minutes duration; their expense was too great to give full 24-hour coverage. In any case, these measures did not attack the problem at its source.

Local application of a water soluble chlorophyll derivative has acquired some reputation as a wound healing accelerator and deodorant of chronic infected wounds.[1,2,3,4] Moreover, recent reports that the oral administration of a chlorophyll derivative was useful in reducing body odors[5,6] led to the suggestion that such a preparation might prove helpful in "deodorizing" low-grade patients.

We selected for trial a tablet containing 100 mg. of a chlorophyll derivative, prepared by the Westcott process.* Ward attendants were not told the nature of the preparation and what was expected of it. Orders were issued to give each patient in one wing of the ward a single tablet twice daily, at 12-hour intervals. This was done for three days. During the second day of the treatment, the attendant in charge reported a marked reduction in the odor in the "treated wing" as compared with that of the "control wing." We then gave orders that all patients in both wings were to receive the tablets.

During this period all deodorizing and resinous antiseptics were removed. Twenty-four hours following the first administration of tablets to all patients in the ward, the reduction in odor was striking. Even though attendants and ward personnel had still not been informed why the tablets were given, most were certain that they were directly responsible for the improvement. Body odor was markedly reduced during the administration of the tablets, and feces and urine freshly evacuated were free of odor.

Urines and blood counts taken of a random 10 per cent sample of the low-grade patients before, during and after administration of the tablets showed no abnormality. The stools appeared darker in color. Not one of the 125 patients who received medication had any side effects either of a digestive or an allergic nature.

One other chlorophyll preparation was given to a selected number of patients, but we found it lacked the long-range duration of

*Readers desiring to know the name of the firm manufacturing this product should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10.

the first preparation used, and larger doses were required.

With the success of chlorophyll we have in no way halted the meticulous attention to hygiene among low-grade patients. Such residual odors as remain, however, are reduced strikingly by the oral administration of chlorophyll derivative.

The price of the tablets although expensive (at the time of writing) still compare favorably in price with the present deodorant sprays. The value of the tablets is no longer lasting and free from any side-effects.

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Medical notes and comment

X-ray procedures

Stressing the importance of program coordination by a physician trained in tuberculosis work, the Cleveland Hospital Council has approved a list of suggested procedures for hospitals operating miniature chest x-ray equipment. High point of the recommendation is the insistence upon the routine x-ray miniature chest film of every person who comes into the hospital. Annual repeat films are recommended for volunteer workers in the hospital and semi-annual examinations are recommended for nurses, resident medical staff, medical students, maids, orderlies, food handlers, x-ray and laboratory technicians.

Routine chest x-rays are also recommended for all patients on admission both to the inservice and to the outpatient clinic. Recognizing the limitations of the miniature chest film the council urges hospitals to follow-up all films that indicate possible or probable chest pathology so that tuberculosis can be discovered and treated quickly. Close cooperation with the health authorities is evident by the recommendation that unless a diagnostic film has indicated a diagnosis other than tuberculosis, the hospital should send a copy of the miniature film report together with such information as is available regarding the individual concerned to the health commissioner of the health district wherein the hospital is located within 30 days.

A uniform method for compiling miniature chest film operating costs is also suggested. Participating member hospitals are invited to make a statistical report to the council showing the total number of satisfactory miniature chest x-ray films for the various categories of outpatients and personnel. These procedures should materially assist in the early detection and elimination of pulmonary tuberculosis in the Cleveland area. The Cleveland Hospital Council has initiated an important cooperative venture that should be emulated by every community.

Cobalt - 60

The radio isotope of cobalt is making a fair bid to displace radium and radon as a method of treatment of cancer. The radioactive properties of this element make it most suitable for interstitial and intercavitary therapy. It is said to offer the following advantages:

1. It is easier to handle. It can be packed in stainless steel hypodermic needle tubing which resists damage during insertion and handling. In addition, the smaller diameter of the needle tubing reduces damage to tissue as a result of needle insertion.

2. Cobalt-60 sources cannot leak out of the needle since there are no gaseous radioactive daughter products as in radon. In the event that it enters the body, it will not localize in bone.

3. Cobalt-60 assures uniform irradiation.

4. Cobalt needles can be made with magnetic sheaths for easy handling.

5. Cobalt-60 is cheaper than radium or radon. It can be obtained in greater variety and has greater adaptability to body contour. A greater number of types and configurations of needles can be purchased so that a selection is offered to the treating surgeon. Its main drawback is that its potency is difficult to establish. It has a half-life of 5.3 years. This means that in 5.3 years it loses half of its power. Nevertheless, tables have been worked out to calculate the exact potency of cobalt-60 at any given time. This new radioactive isotope is an important addition to the facilities of hospitals for the treatment of cancer. It can be purchased together with its accessory items including needle pushers and needle extractors, needle inserting forceps and shielded needle containers from commercial dealers.

Gas machine sparks

An interesting piece of research work by two Swedish scientists is reported in "Current Researches in Anesthesia and Analgesia" for November-December, 1952. Starting with the assumption that the breathing bag is the weak point in the anesthetic gas machine unit, Gordh and Egmark, of Stockholm, collected evidence showing that the rubber parts of the gas machine may collect a tension high enough to produce a spark.

A five liter bag was covered on two opposite sides by tinfoil (aluminum foil) and these were each contacted with an electrostatic voltmeter. Filling the bag with oxygen generated a voltage of 250, and breathing in the apparatus gave a potential of 300 volts. If the bag was stroked previously with a woolen object, up to 2,000 volts were obtained. If the bag

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The dependable hypotensive action of Solution Intramuscular Veriloid makes this unique extract of Veratrum viride alkaloids highly valuable in mild and moderate pre-eclampsia. It produces a prompt initial fall in blood pressure, and, given at intervals of 3 to 6 hours, it then holds the tension at or near normotensive levels until delivery occurs.

Note These Results

In a series* of 56 patients with mild to severe pre-eclampsia, excellent results were obtained in 47 patients, good results in 4, and fair results in 5. In all patients the significantly depressed blood pressure was maintained until delivery took place. In 5 cases of postpartum pre-eclampsia, the results were especially gratifying since only a single injection was required in each patient.

Solution Intramuscular Veriloid merits ready availability in the labor and delivery rooms; it can aid significantly in the management of the eclamptic patient.

In Hypertension

Given in proper dosage, Solution Intramuscular Veriloid offers a positive means of lowering the blood pressure not only in eclampsia, but also in malignant hypertension, encephalopathy, and hypertensive crises. A single dose produces its maximum effect in 60 to 90 minutes and exerts a hypotensive influence for 3 to 6 hours. Through repeated injections, the blood pressure may be depressed for hours or even days, depending upon the therapeutic need.

*Finnerty, F. A., Jr., and Fuchs, G. J.: Washington, D. C., to be published.

Solution Intramuscular Veriloid, containing 1.0 mg. of alkavervir per cc. of buffered isotonic aqueous solution incorporating one per cent procaine hydrochloride, is available through all pharmacies in 2 cc. ampuls packed 6 ampuls per box.

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was rinsed with tap water no charge was obtained until it was dry.

With the dry bag, a radon tube of 50 mg. was kept at a distance of 50 cm. from the bag and tension on the voltmeter rapidly sank to zero. Repeated charging of the bag was impossible even after heavy stroking with wool. The radon was taken away and after five minutes it was again possible to charge the bag. Thus, there was no doubt that the presence of a radioactive substance eliminated all static electricity in its surroundings. The question was how to make a permanent radioactive charge in the bag.

A small piece of radon (radium emanation) containing one millicurie radon in a small glass capillary was crushed in a breathing bag. The mechanism is supposed to be as follows: When the radon, which is a gas, disintegrates, radium D is produced. This substance is solid and tends to become deposited on the surface with which it comes into contact. In this experiment 1/2000 millicurie is produced and these atoms will be deposited on the walls of the rubber bag. By their radiation, the surrounding gas will be ionized, rendering it conductive and thus preventing static electricity. Deposit of this radioactive substance is nearly permanent as the active part will disintegrate only 50 per cent after 22 years. The amount of radium D atoms is so small that the risk of radiation injury is out of the question.

Four bags were prepared for experimentation. By striking the expanded bags with nylon the highest voltage values were obtained and all gave around 2,000 volts on the voltmeter, and more than 300 volts on the electrometer. Two of the bags were then prepared with radon, 1/1000 and 2/1000 millicurie, respectively, and left in the open air slightly distended. Two days later, the experiment was repeated. The untreated bags responded with 2,500 volts on the voltmeter and 300 volts on the electrometer. The radioactive bags gave zero readings on both the voltmeter and the electrometer.

The authors insist that the experiment should be considered as preliminary only. They have, nevertheless, made a valuable contribution to the hospital field by the publication of this information.

British health service

People who are intrigued by the theoretical arguments of the apologists for control of medicine and hospitalization by the federal government should be given the opportunity to see how it works out in practice or at least to read reports of the practical results of government medicine. Even the loyal British get fed up with the National Health Service and feel constrained, now and again, to criticize it. An editorial in the November 22, 1952 issue of the *British Medical Journal*, page 1140, points out in a restrained way, what will happen to the quality of service when the staffs of government hospitals are reduced in size.

It points out that the state, through the National Health Service, has guaranteed a comprehensive free medical service to all population but cannot possibly fulfill the terms of its guarantee unless hospitals are properly equipped and staffed. The party in power, however, has other problems. It must insure reelection and this can be encouraged by reducing taxes. Reduced taxes result in reduced services and reduced services reduce the government's payroll. This is old stuff to some of our federal medical services. We wonder how it will turn out in the end.

Skin disinfection

One of the petty annoyances that beset operating room supervisors and administrators of hospitals is the wide divergence of opinion in the medical profession regarding the agent that should be used to disinfect skin before puncture or incision is undertaken.

The fancy preparations have had little in the way of scientific investigation to back up their exaggerated claims, with the doubtful exception of "experiments" conducted in a laboratory under the auspices of the company that markets them.

The old established skin disinfectants consisting of ordinary tincture of iodine or 70 per cent alcohol always seemed to top the list when independent investigations are undertaken, whether they be in England, Germany, Switzerland or the United States.

Once again, we are offered an independent investigation by the department of pathology of St. Bartholomew's Hospital, of London, England. This investigation is reported by Dr. Peter Story in the *British Medical Journal* of November 22, 1952, page 1128. So impressed was the editor of the *Journal* with this investigation that he further recommended it in his editorial.

To those hospital administrators, nurse supervisors and directors of operating rooms who suffer from the whims of surgeons who have succumbed to the blandishments of antiseptic salesmen, both the article and the editorial are highly recommended. They offer scientific evidence that the old-fashioned 1 per cent iodine and 70 per cent industrial alcohol are still the best skin disinfectants that are known to medical science.

Premature infants

A remarkable study by Dr. Ingvar Alm, chief surgeon of the "Fachska Bansjukhuset," one of the most modern children's hospitals in Sweden, promises to be of great significance in the scientific world. The study relates to the follow-up of 1,000 infants born prematurely during the period 1902-1921.

Dr. Alm's study shows that the prematurely born infant runs no greater risk of physical or mental handicap than a full-term infant provided that he suffers no birth injury and that he survives the dangers of the first 18 months of life.

Main conclusions of the study are that 85 per cent of infants born prematurely were found physically fit for military service and completed same, thus equalling the Swedish average for those born at term.

The second conclusion is that there were fewer criminals and alcoholics among prematures than among those born at full term. Their earnings also compared favorably with persons born at the end of the regular period of gestation.

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ICE WATER

ICE CUBES

Tomac

FREEZ-A-BANK

gives you all 3...right now!

Ice packs, ice water, ice cubes—all three are instantly available in the Freez-A-Bank. In the lower compartment (shown closed) are 36 Freez-A-Bags in three shapes and sizes. Each is made of soft, pliable rubber with permanently sealed-in liquid that will not harden or lump, even at temperatures colder than ice. Lasts for years.

Upper compartment (shown at right) holds 20 water pitchers or an ample number of ice cube trays. Pitchers are ⅓ filled with water, then frozen solid to 15° F. When water is added and served, it stays ice-cold for seven hours, despite room temperature.

PAYS FOR ITSELF... AND QUICKLY

May we send you the complete story?

This Low Boy model holds Freez-A-Bags only. Furnished top for counter use

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No Other Floor Lamp Offers You So Much!

Here, truly, is the most functionally designed of all floor lamps. A full three years of research preceded its introduction. Three years in which to incorporate every convenience feature. Three years in which to eliminate the shortcomings of previous patient room lamps. Note its many important advantages for which you pay no premium at all.

Simple turn of shade provides effective spot light for close examinations

Switches and outlet at convenient mattress level. Easily seen and reached

Nite-lite in base reflects light parallel to floor. No patient disturbance

Available in Silvermist, Dove Green, Bayou Green, Brown and Dusty Rose

the Tomac Floor Lamp Outstanding Features from Shade to Base

- Perfectly balanced design withstands tipping. Lamp remains upright despite unusually heavy jolts and jars.
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- Lamp can be completely disassembled without special tools. Every part catalogued and stocked for prompt replacement.
- Heat-proof shade cannot burn patient or attendant.
- Indirect lighting is scientifically correct for eye-resting comfort. Shade is permanently adjusted for proper reading illumination.
- Electrical outlet at convenient mattress level for radio, electric razor and other accessories. Outlet safeguarded against liquids.

Manual of Hospital Maintenance

newest addition to literature

JUST OFF THE press, this new manual* published by the American Hospital Association will be of interest to all who are concerned with hospital buildings and equipment. The purpose of this convenient (6 x 9-inch size, 116 page), attractively bound volume, as stated in the foreword, is modest, "To familiarize hospital executives and hospital boards with some of the maintenance problems of the physical structure; its equipment and appurtenances; and similar matters closely related to the maintenance problem."

In fulfilling this purpose, the Committee on Repairs and Maintenance of the Council on Hospital Planning and Plant Operation has produced, in compact form, a well indexed and self-explained manual which covers the basic principles of the diverse and complicated features of the hospital plant. Because it is basic it is applicable to the small hospital and the large hospital alike. Organization and administrative procedures for operating and maintaining the physical plant are succinctly outlined. Purchasing and storage of maintenance supplies are also treated briefly.

This volume is not an encyclopedia of "how to fix it," but is intended as a general guide. Since it deals with purposes and functions it comprises good reading for the administrator and will be as timely for the executive who is involved with planning new construction as for the person who is operating and maintaining an established plant. Architects may also find this manual to be a useful reference on some of the aspects of hospital planning.

The manual contains glossaries of technical terms, check lists and other aids. It is also alphabetically indexed for ready reference and contains a list of suggested readings on hospital maintenance comprising up-to-date and pertinent literature relative to hospital maintenance. It is a composite of contributions by many authorities. Chapters were written by I. E. Behrman, William G. Illinger, Burton B. Lovell Jr., Sam Gilmer, T. Joseph Hogan, Leland J. Mamer, Joseph W. Degen and Louis L. Brega, all members of the committee assigned to prepare the manual, with the assistance of Roy Hudenburg.

If you are concerned with operating and maintaining a hospital or planning one, you will want to read this manual and then keep it handy for reference.—CLIFFORD WOLFE.

*MANUAL OF HOSPITAL MAINTENANCE. American Hospital Association, Chicago. 1952. 116 p. $1.50.

Operating room institute

PROCEEDINGS OF THE INSTITUTE ON OPERATING ROOM ADMINISTRATION. American Hospital Association, Chicago. 1952. 184 p. $3.

The transcript of the Institute on Operating Room Administration is the compilation of papers presented at the first operating room institute conducted by the American Hospital Association in cosponsorship with the National Committee for the Improvement of Nursing Services of the National League for Nursing.

The topics as presented carried out the purpose of the operating room administration institute which was designed to supplement the operating room supervisor's knowledge and skills in the art of management.

In addition to a panel discussion on the role of the operating room supervisor on the administrative team, presented by a director of nurses, a hospital administrator, a surgeon and an operating room supervisor, topics were covered relating to the principles of administration, interpersonal relations and supervision pertinent to operating room supervision. Work simplification and job analysis techniques were included as tools of management.

Other topics presented, of vital interest to the operating room supervisor in her expanding role, were: Principles and methods of sterilization; orientation and in-service program for the operating room technicians; purchasing hints for operating room supervisors; safety program in the operating room and architectural planning and equipping of the operating room.

This continuity of related information should provide a ready reference for central supply room supervisors and obstetrical supervisors, as well as the operating room supervisors.

It was the intent of those responsible for planning publication of this manual to preserve the valuable information presented at the institute in order that those not able to attend might share in the benefits of such a program. The publication fills a definite need for material in this field.—MARIAN L. FOX, R.N.

Tuberculosis staffing

CUES TO STAFFING TUBERCULOSIS UNITS IN HOSPITALS, a guide for the Nursing Department. National Tuberculosis Association, New York. 1952. 28 p.

This 28-page manual was prepared by the Tuberculosis Advis-

Inquiries about books reviewed in the Literature department should be addressed to the American Hospital Association Library — Asa S. Bacon Memorial, 18 E. Division Street, Chicago 10. The department is edited by Helen V. Pruitt, librarian.

ory Nursing Services of the National League for Nursing, Inc., for the National Tuberculosis Association.

The committee preparing this manual supported the recommendation that medical and surgical tuberculosis patients need the same quality of nursing care as general medical and surgical patients.

Hospital administrators, directors of nursing service and nursing education and other groups interested in tuberculosis nursing should find this a valuable guide in determining staffing needs.

This manual sets up standards for staffing of professional nursing service and other nursing personnel by taking into account the therapy program, hospitalization policies, hospital facilities and the preventive program in addition to the actual nursing needs of the patient. The inclusion of the time allowance for "intangibles" of good nursing will interest those sincerely concerned with meeting the peculiar psychological, physical and material needs of the tuberculosis patient. The guides used in estimating staffing quotas are easily interpreted and adaptable to varying hospital census.

By present day staffing standards the recommendations will seem high and unattainable for many. This manual, in setting up the criteria for good nursing care for the tuberculous patient, could be used by those concerned with the necessity of interpreting to the community that "Patients with tuberculosis need a fair share of the nursing resources available in each locality both in time of plenty and in time of scarcity."

This manual may be secured from local and state tuberculosis associations.—MARIAN L. FOX, R.N.

Century of progress

THE FIRST HUNDRED YEARS OF THE MOUNT SINAI HOSPITAL OF NEW YORK, 1852-1952. Joseph Hirsh and Beka Doherty. Random House, New York. 1952. 364 p. $5.

"The First Hundred Years" is an apt title for this stimulating account of the development of the Mt. Sinai Hospital of New York, for the entire history is testimony to the forward thinking and movement of the hospital organization.

Mt. Sinai Hospital, first established as the Jews' Hospital in 1852, played an important role in the Civil War and maintained its influence and military contribution through the first and second world wars, sending a base hospital overseas both times. Perhaps two of the greatest contributions made by Mt. Sinai are in the fields of medical education and hospital administration. In the latter field, it was Dr. S. S. Goldwater who, in his 25 years as administrator, made a far-reaching and enduring impression on the growing profession of hospital administration. For another 25 years Dr. Joseph Turner served in this same capacity, and he upheld the standards set by Dr. Goldwater. Thus, for half of its life, the hospital has had the leadership which brought it to the front. As it has increased in size and extended its facilities and services it has maintained its interest in medical education and medical research.

The very important role played by the board of trustees in the growth of the hospital is defined throughout the history. The hospital has been fortunate in the enlightened and intelligent interest the board has taken in its behalf.

The reader of this engrossing story will be impressed by the fact that it is told against the background of rapidly changing social and economic situations—the hospital has not been treated as an institution existing in a vacuum. As would be true of any well documented research, there are ample appendices with factual information and data arranged chronologically.

Briefly noted

(Copies of these publications may be had on loan from the Library of the American Hospital Association.)

The Connecticut Hospital Association recently has issued a cost accounting manual for its member hospitals. It provides a system of uniform reporting and a cost analysis procedure for developing unit and departmental costs. The forms follow closely the Chart of Accounts in the "Handbook on Accounting, Statistics and Business Office Procedures for Hospitals," Section I, published by the American Hospital Association and distributed to its members.

Information prepared by the hospital and certified in accordance with this manual will be recognized for purposes of reimbursement by the Connecticut Hospital Cost Commission for state cases, by the Connecticut Hospital Service, Inc., for Blue Cross cases, and by the stock and mutual insurance carriers for workmen's compensation cases.

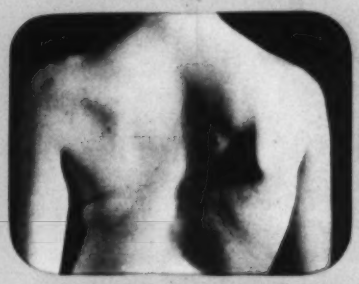
VOLUNTEER PARTICIPATION IN PSYCHIATRIC HOSPITAL SERVICES, *an organization manual and program guide,* is the title of a new publication of the National Committee for Mental Hygiene. The manual was prepared by Mrs. Marjorie H. Frank, assistant director of state and local organization, and is specially designed for use by the state and local mental hygiene societies which are in a position to sponsor and coordinate such programs. The same outline and guide can be followed in the development of volunteer services in civilian psychiatric hospitals. The principal sections in the book are devoted to organization, recruitment and selection of the volunteers and their education and training. There is an excellent section on the orientation course which is to be given by the sponsoring agency in the community.

A statistical study of hospitals reporting dental departments has been released by the American Dental Association. In addition to the tabular information showing the distribution of hospitals reporting dental departments by state, size and type of hospital, there is a complete listing of hospitals by name and location. A coding device indicates the pertinent information about both the hospital and the dental department. Much of the data was obtained from HOSPITALS, June 1952, Part II, the Administrators Guide Issue. This 107-page reference source was compiled by the Bureau of Economic Research and Statistics of the Council on Hospital Dental Service of the American Dental Association.

Record it

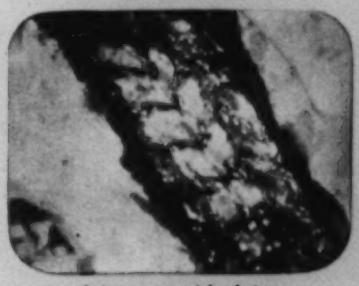
...with motion
in black and white or color

BECAUSE hearing about it, or reading about it, lacks the impact of seeing it, motion pictures play an increasingly important role in teaching. Furthermore, a motion-picture camera can capture a surgical technic completely . . . record every detail accurately—objectively—for showing days, weeks, years later.

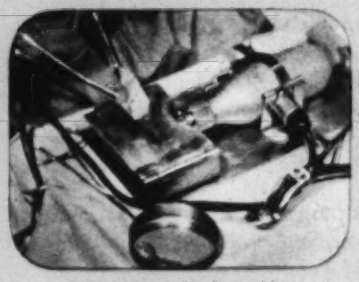


Patient with idiopathic scoliosis.

Surgeon beginning the operation.



Spine prepared for fusion.



Assistant preparing bone chips.

Placing bone chips along spine.

Appearance before closure.

From the "Bone Bank" film, prepared by the Hospital for Special Surgery.

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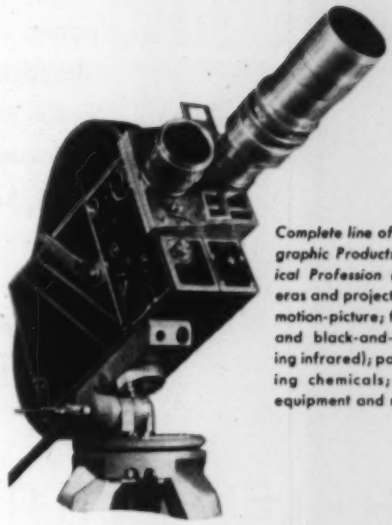

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(THE TRICK QUESTION)

The president of a hospital board, for which we have recently undertaken to direct a campaign, described to us the method he and his board used to select fund-raising counsel.

1. They obtained a list of most of the reputable fund raisers.

2. A list was secured of campaigns conducted by each.

3. They investigated . . . by telephone . . . each of these recommendations, inquiring as to goal, ultimate success, methods used, etc. As was to be expected, almost all reported a job well done. Then the board asked what it called 'the trick question' . . . "If you were to have another campaign, *would you have 'em back?*" Our client reported that there was only one fund-raising firm for whom the answer was consistantly, an enthusiastic, "Yes" . . . *Haney Associates.*

It is our belief that the measure of a firm's worth lies, not only in the ultimate success of its undertakings, but in the manner and spirit in which these are accomplished.

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PERSONAL News

ADELAIDE BYINGTON CUSHING, R.N., retired as administrator of the Eye and Ear Hospital of Pittsburgh, January 1. Succeeding Miss Cushing is MARTHA C. ZAVONIA, R.N., who has served as the associate administrator since 1950.

Miss Cushing's nursing and hospital career includes 19 months' overseas duty with the University of Pittsburgh Base Hospital 27 during World War I and the post of superintendent of the Pittsburgh Clinics, which she vacated to assume the administratorship of the Eye and Ear Hospital in 1925. Under her guidance and administration, the Eye and Ear Hospital expanded from a 55-bed structure to 119-bed capacity, and the hospital opened an Audiology department in 1948 and the Eye Bank of Pittsburgh in September, 1952.

Miss Cushing holds membership in the American College of Hospital Administrators, Pennsylvania and National League for Nursing, the Pennsylvania and American Hospital Associations and the Southwestern Hospital Conference.

GEORGE A. HAY, administrator of the Hospital of the Women's Medical College of Pennsylvania, has been appointed chairman of the Philadelphia Regional Hospital Planning Committee. The eight-man committee makes recommendations for the use of Federal funds under the Hill-Burton Act for hospital building programs in the Philadelphia area.

MR. HAY

In 1951 Mr. Hay replaced MAJOR ROGER A. GREENE on the healing arts advisory committee of the State of Pennsylvania Department of Public Assistance.

JOSEPH B. FOWLER became administrator of Cortland County (N.Y.) Hospital, January 12. Assistant administrator of the Hospital of the Good Shepherd, Syracuse, for six and a half years, Mr. Fowler is a member of the American College of Hospital Administrators. JAMES H. ABBOTT, formerly of the U. S. Public Health Service, Washington, D.C., is Mr. Fowler's successor.

DR. DORA RULAND, medical director of Woman's Hospital, Philadelphia, has been named the hospital's administrator. MARY L. MILNER is now assistant administrator. FLOYD K. MCTYIER has been employed as business director.

JOHN P. FLETCHER has joined the staff of J. C. Blair Memorial Hospital, Huntingdon, Pa., as administrative manager. He succeeds HARRY R. TULLY, who is now at Gnaden Huetten Memorial Hospital, Lehighton.

Mr. Fletcher has spent nearly three years as second assistant director in charge of purchases at the 450-bed Paterson (N. J.) General Hospital.

DR. SAMUEL W. FRIEDMAN has been appointed administrator of the Southern Division of the Albert Einstein Medical Center, Philadelphia. He succeeds MARK BERKE, who is now director of Mount Zion Hospital, San Francisco.

HAROLD WARREN, administrator of Hopkins County Memorial Hospital, Sulphur Springs, Texas, has been selected to administer the Central Baptist Hospital, Lexington, Ky., beginning January 15. The 175-bed hospital is scheduled to open in 1954.

J. GUS HENDERSON has been named assistant administrator of the City-County Hospital, Fort Worth. Mr. Henderson has been the finance officer of the Veterans Administration Hospital, Amarillo, since June 1948.

NORMAN P. MORTENSEN and EVA M. DICKSON have resigned as president and superintendent, respectively, of the Greenville (Pa.) Hospital. WILLIAM EDDY is acting superintendent and LUTHER J. KUDER is the new president.

JOHN W. ETSWEILER, Jr. is now administrator of the Van Wert County (Ohio) Hospital. Mr. Etsweiler was formerly medical administrator of the Standard Oil Company and assistant director of the Malden (Mass.) Hospital.

COLEMAN H. FOOTE has become administrator of the Lapeer County (Mich.) General Hospital.

ROBERT T. JACOBSON, who was assistant administrator of the Ferguson-Droste-Ferguson Clinic, Grand Rapids, Mich. has been recalled to active duty in the U. S. Air Force.

ELLIS H. LINDHORST has been appointed administrator of the Logan County Hospital, Russellville, Ky. He was formerly assistant administrator of the Hazelwood Hospital, Louisville.

Mr. Lindhorst replaced HAROLD J. PILON, who is the new administrator of St. Luke's Hospital, St. Paul, Minn.

ERNEST F. GAMACHE has joined the staff of the Roosevelt Hospital, New York City, as director of development. Prior to his affiliation with Roosevelt Hospital, Mr. Gamache was executive director of the American Foundation for

Tropical Medicine, and the Liberian Institute of the American Foundation, two nonprofit foundations established to assist and conduct research in tropical medicine.

DAVID A. GEE has been named assistant director of the Jewish Hospital, St. Louis. Mr. Gee, who has served the hospital as administrative assistant for the past year and a half, is a member of the American Hospital Association and the Missouri Hospital Association and is a nominee to the American College of Hospital Administrators.

SISTER M. CONSOLATA, O.S.B., R.N., has become administrator of Our Lady of Lourdes Hospital, Norfolk, Va. Sister Consolata, who previously has been superior of Sacred Heart Hospital, Lynch, Nebr., succeeds MOTHER M. MATHILDE, who has retired because of ill health.

JOHN PROPPS, former administrator of the Woodward (Okla.) Memorial Hospital, has resigned his position to become a special research consultant to the Oklahoma State Board of Health. J. E. SUMMERS has been named new administrator of the hospital.

ORVAL H. GUENTHER, C.P.A., is now institutions business manager of the Milwaukee County Institutions and Departments. Mr. Guenther will coordinate and direct the business activities of the seven institutions and five departments, including the Milwaukee County Hospital, Hospital for Mental Diseases, Milwaukee County Asylum, Muirdale Tuberculosis Sanatorium, and Children's Home and Infirmary.

For the last 11 years, Mr. Guenther has been the chief accountant of the institutions. He is a member of the Wisconsin Society of Certified Public Accountants, the American Association of Hospital Accountants, and the Wisconsin Hospital Association.

RALPH H. GALE, director, Saint John General Hospital, New Brunswick, Canada, retired from the field December 31 after 32 years of service with the hospital.

DALE K. TULLER has been appointed an assistant vice-president of the Presbyterian Hospital in the City of New York. Mr. Tuller came to the Presbyterian Hospital in October 1945 as administrative assistant responsible for food services and related activities. In his new post effective January 1, Mr. Tuller will assume additional responsibilities in the management of the Pressbyterian Hospital.

MRS. AILEEN JEISY JOHNSON, R.N., of Afton, Minn., has become director of nurses and the school of nursing at Orange County (Calif.) General Hospital. Mrs. Johnson succeeds MRS. DOROTHY DALADIC, who has served in the same capacity for the past two years.

Mrs. Johnson has held nursing supervisory positions at the Illinois

"What do you mean... it's *not* allergic to oxygen", demanded the administrator.

"How can an oxygen tent be allergic to oxygen?" he snorted. "Why the purpose of such equipment is to *administer* oxygen."

May we answer . . . yes of course, but the allergy we refer to is an allergy of metals . . . Rust and Corrosion. And it costs you thousands of dollars a year in maintenance, replacements and dangerous malfunctions.

Some metals, we know, rust in normal air with only *21% oxygen.* What happens if we expose those metals to 100% oxygen as we do here . . . try it—you'll almost SEE the rust form . . . try aluminum and plastic too.

That's why the Melco Oxygen Tent is "sealed-for-safety" in aluminum. That's why the cooling chamber is made of an envelope of non-porous aluminum sheet sealed by Heliarc . . . why the entire unit is made of rust-resistant aluminum and corrosion-proof plastic.

Don't take corrosion for granted . . . it costs too much. If you're considering the purchase of new equipment, may we suggest you inspect the only unit *not allergic* to oxygen, the Melco Oxygen Tent.

Why not write today for further information and your new, 1953 catalog of complete oxygen therapy equipment.

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The Melco *Continuous* Oxygen Analyzer

Provides constant, visual evidence of the therapy your patient receives. Write for the full story on this unique instrument.

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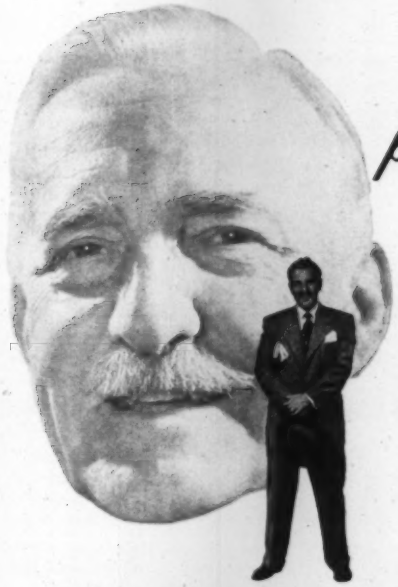

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THE DIURETIC TABLETS THAT WORK LIKE AN INJECTION

lifetime therapy —

NEOHYDRIN helps keep the cardiac patient in fluid and electrolyte balance for his lifetime — a lifetime that might be impossible without such control of water and salt metabolism.

day in, day out diuresis —

NEOHYDRIN daily, maintains a steady, uninterrupted diuresis. This allows more liberal salt intake which benefits the patient psychologically. Even more important, liberalized salt intake permits the daily physiologic intake and output of sodium required by the body and safeguards against salt depletion.

how to use this new drug

Maintenance of the edema-free state has been accomplished with as little as one NEOHYDRIN Tablet a day. Often this dosage of NEOHYDRIN will obtain per week an effect comparable to a weekly injection of MERCUHYDRIN.® When more intensive therapy is required one tablet or more three times daily may be prescribed as determined by the physician.

Gradual attainment of the ultimate maintenance dosage is recommended to preclude gastrointestinal upset which may occur in occasional patients with immediate high dosage. Though sustained, the onset of NEOHYDRIN diuresis is gradual. Injections of MERCUHYDRIN will be initially necessary in acute severe decompensation.

NEOHYDRIN is contraindicated in acute nephritis.

Any patient receiving a diuretic should ingest daily a glass of orange juice or other supplementary source of potassium.

prescribe NEOHYDRIN when indicated in

congestive heart failure • recurring edema and ascites • cardiac asthma • hypertensive heart disease dyspnea of cardiac origin • arteriosclerotic heart disease • fluid retention masked by obesity • and, for patients averse to their low-salt diet.

packaging Bottles of 50 tablets. There are 18.3 mg. of 3-chloromercuri-2-methoxy-propylurea in each tablet.

Leadership in diuretic research N-4

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School for the Deaf; Cook County Hospital, Chicago; Children's Mercy Hospital, Kansas City, Mo; Kern County Hospital, Bakersfield, Calif.; and Good Samaritan Hospital, Dayton. She also served as nursing educational adviser with the state board of nurse examiners of Minnesota.

DR. WANSAUN CHIANG has been appointed secretariat of the National Taiwan (Formosa) University Hospital in Taipei. Dr. Chiang was chief resident at the same hospital.

LT. COL. JAMES T. RICHARDS, M.S.C., U.S. Army, has been transferred from Brooke Army Medical Center at Fort Sam Houston, Texas, to the Army Medical Center at Carlisle Barracks, Pa.

MATTHEW F. MCNULTY, Jr. is now assistant manager of the Veterans Administration Hospital at Birmingham.

The Veterans Administration announced several hospital appointments recently.

DR. RALPH S. METHENY, manager of the Veterans Administration Hospital at Altoona, Pa., has been appointed manager of the new veterans hospital at Syracuse, N. Y.

DR. OLIVER W. GREER, chief of professional services at the San Francisco veterans hospital, has been transferred to the veterans hospital at Newington, Conn., as manager.

PHILLIP L. COLLINS, formerly manager of the Veterans Administration Center at Kecoughtan, Va., is the new manager of the veterans hospital, Oteen, N. C. He succeeds MAJ. GEN. JOHN B. WOGAN, who is retiring.

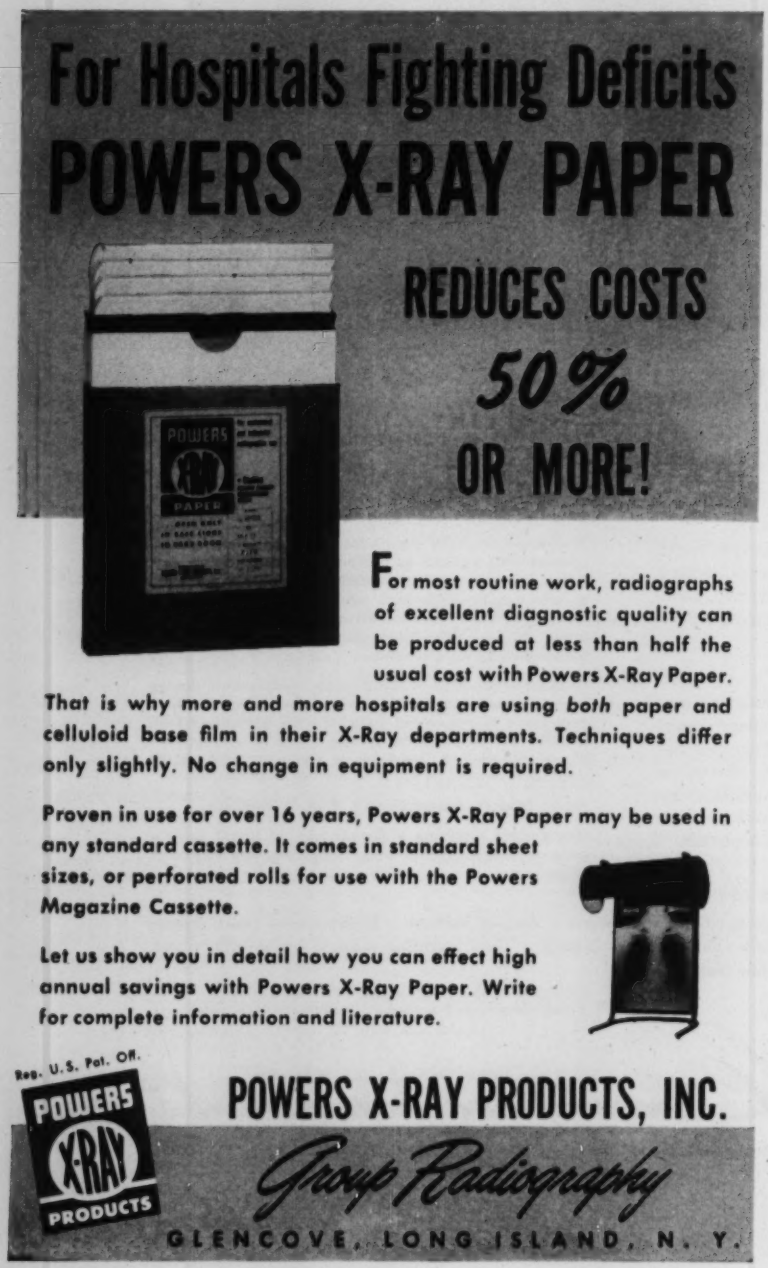
HERBERT A. CHASE is now assistant manager of the Veterans Administration Hospital in Aspinwall, Pa. He formerly was assistant manager of the veterans hospital in Richmond, Va.

DR. PETER J. VOLPE, manager of the Veterans Administration Hospital, Aspinwall, Pa., has been named manager of the Veterans Administration Hospital, at Hines, Ill. He succeeds DR. KELSO A. CARROLL, who has been transferred to the central office in Washington, D.C., as assistant chief medical director for professional services.

REUBEN COHEN, assistant manager of the Brooklyn (N.Y.) Veterans Administration Hospital, replaces Mr. Collins at the Kecoughtan Veterans Administration Center.

DUANE E. JOHNSON succeeds JAMES G. CARR, JR. as administrator of the University of Nebraska Hospital, Omaha. Mr. Johnson was formerly administrator of Audubon County (Iowa) Memorial Hospital and assistant administrator of Dr. W. H. Groves Latter-Day Saints Hospital, Salt Lake City. Mr. Carr's new post is administrator of Natrona County Hospital, Casper, Wyo.

MARIAN F. CIPAIA is now administrative assistant in the Clinical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POWERS X-RAY PAPER
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Proven in use for over 16 years, Powers X-Ray Paper may be used in any standard cassette. It comes in standard sheet sizes, or perforated rolls for use with the Powers Magazine Cassette.
Let us show you in detail how you can effect high annual savings with Powers X-Ray Paper. Write for complete information and literature.
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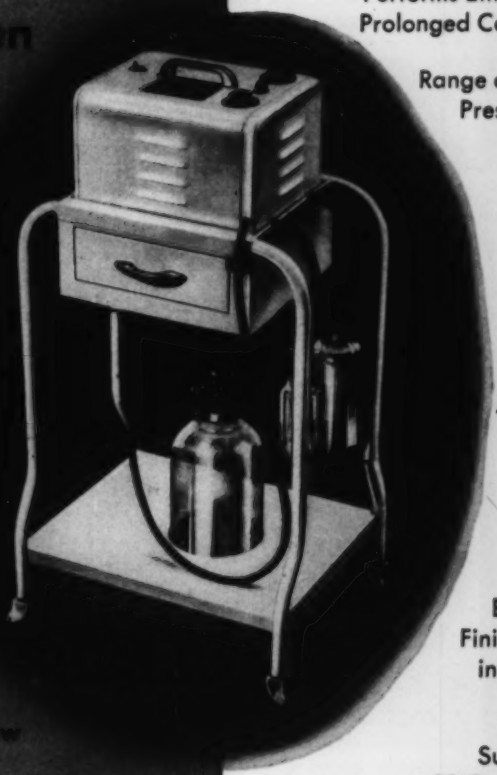

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The advanced development of this new compact, mobile Sklar Electric Evacuator is designed specifically to adequately provide for the many and variable indications for controlled low grade suction and pressure in preoperative and postoperative procedures.

The versatile and dependable performance of this essential unit, perfected after several years of research, fulfills the ever-present demand for these clinical requirements.

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Performs Efficiently During Prolonged Continuous Use.

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Suction Calibrated from 50 to 250 cm. Water.

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TWO YEAR GUARANTEE

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SURGICAL INSTRUMENTS . . . SUCTION PRESSURE AND ANESTHESIA APPARATUS . . . RESEARCH AND DEVELOPMENT

A SKLAR PRODUCT

Laboratory at Mount Sinai Hospital, Chicago. She was formerly business manager of Theda Clark Memorial Hospital, Neenah, Wis. Her successor was ROBERT A. SANDAHL, who was formerly assistant administrator of the Wausau (Wis.) Memorial Hospital.

ELIZABETH J. SCHREI is the new administrator of the Mendota (Ill.) Community Hospital. Miss Schrei completed her residency in hospital administration at Galesburg (Ill.) Cottage Hospital and later served as assistant administrator in that institution.

GERTRUDE E. COPELAND has resigned as superintendent of Independence (Mo.) Sanitarium and Hospital. Miss Copeland, who held the position for 30 years, has been succeeded by A. NEAL DEAVER.

DR. WALTER A. ROHLFING resigned January 31 as administrator of the Fresno County (Calif.) General Hospital. Dr. Rohlfing will enter private practice in Fresno.

FRANK C. GABRIEL has been named resident administrator of the W. I. Cook Memorial Hospital Center for Children, Fort Worth. Mr. Gabriel was president of the Association of Western Hospitals and organized the New Mexico Hospital Association and the Blue Cross plan of New Mexico.

H. ROBERT CATHCART's title has been changed to administrator rather than acting administrator of the Pennsylvania Hospital Department for Sick and Injured. Mr. Cathcart has been acting administrator for several months. He succeeded JOHN N. HATFIELD, now director of Passavant Hospital in Chicago.

CHARLES W. HOLMES has resigned as assistant director of Foundation Hospital, New Orleans, effective February 15. Mr. Holmes, who is president-elect of the Southeastern Hospital Conference, will become director of the Campbell Orthopedic Clinic and Hospital, Memphis.

PEARL M. CHENG is assisting her husband, DR. CLAUS WOLFGANG GOECKEL in organizing and conducting the government clinics in Tebingtinggi, Deli, Sumatra, Utara, Indonesia.

Deaths

WALTER G. CHRISTIE, for many years superintendent of Presbyterian Hospital, Denver, and formerly active in Mid-West and American Hospital Associations, died November 29 after a prolonged illness. Mr. Christie retired in early 1951 and was succeeded by ROY R. ANDERSON. Mr. Christie is a fellow of the American College of Hospital Administrators and former president of the Colorado Hospital Association and the Denver Public Health Council.

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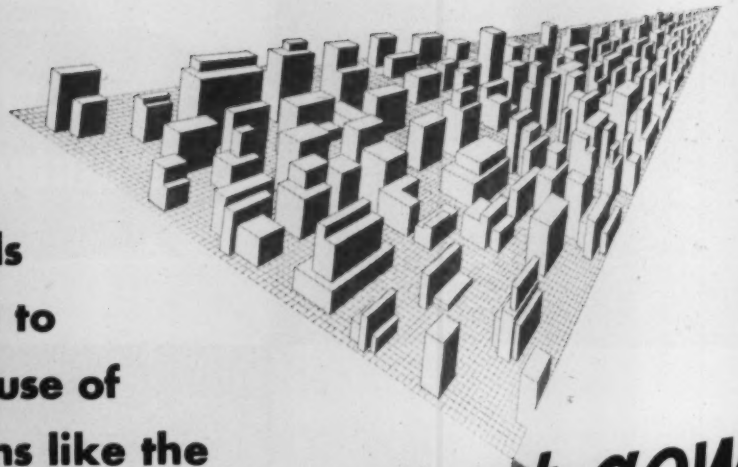

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Planning the hospital laundry to meet modern requirements

JOHN G. STEINLE

PERHAPS ONE of the principal reasons for the high cost of the hospital laundry as compared to commercial standards is the failure to define the activities and objectives of the laundry before it was designed. The laundry should be planned to provide detailed individuality to the needs of the hospital. The length of stay of the patient, the distribution of patient load between medicine and surgery, whether or not a hospital is a teaching hospital and whether there is a school of nursing—all these factors play a tremendous role in determining the size and kind of demand that the laundry must meet.

In planning a new laundry, it is often suggested that a comparative hospital in the same area be studied. Care should be taken to evaluate the system used by the existing hospital in arriving at its "laundry load." Very often techniques are used which would limit the actual use of the laundry. In making a study of a comparable facility, whether or not the full need of the hospital is being met by the laundry should be thoroughly explored.

The type and kind of activity of the hospital is of utmost importance in planning and equipping the hospital laundry. One hundred institutional laundries were recently studied to determine the amount of variation by type of facility. It was found in the acute general hospital that 65 per cent of the normal load was flatwork. In the mental and tuberculosis hospitals, it was 40 per cent; in the chronic disease hospitals, 80 per cent; in children's and isolation hospitals, 65 per cent, and in custodial and convalescent hospitals—which had a high ambulatory rate—the flatwork ran as low as 30 per cent.

In a study of the ancillary activities of the institutions, it was found that the laundry for student and graduate nurses, interns and employees domiciled in the institution was distributed as follows by pound volume: 50 per cent press work, 38 per cent rough dry and only 12 per cent flatwork. Each surgical operation and each delivery required from 20 to 32 pounds. This does not include uniforms. This load was distributed in the ratio of 75 per cent for flatwork and 25 per cent rough dry.

Rather than calculate a laundry load for an acute general hospital upon the total number of beds, a more accurate system would be to plan each acute general bed for approximately 8½ pounds per patient day and plan 25 pounds for each operation and delivery.

The number of employees that are to "live in" should be planned for at 7½ pounds per day if they are to have uniforms laundered and 4 pounds if they are not. This will permit a more accurate adjustment based upon the types and kinds of hospital load.

Perhaps the greatest single error in planning the hospital laundry is the failure to take into consideration emergencies and the heavy normal Monday morning load. The common practice is for a hospital to plan its laundry by estimating the total poundage per week and dividing by 40 (which represents the 40-hour week) to get the hourly estimated load.

Under this system, the hospital does not purchase enough linen, does not have adequate storage space for the dirty laundry and does not have the shelving for the clean laundry to implement this planning. The shortage of linen and storage space generally requires the laundry to do two days' work on Monday. In order to accomplish this, it is necessary to have equipment capable of processing more than the estimated load.

It should be noted, however, that the occupancy of the acute general hospital is usually down somewhat on the weekend. Experience in the past reveals that very little selective surgery is done on the weekend. Consequently the number of operations performed is usually a fraction of those on weekdays. Certain hospitals, however, are attempting to encourage surgeons to schedule surgery at least on Saturday.

In general hospitals the flow of flatwork should be the governing factor in planning the layout. In order to have sufficient work ready for the flatwork ironer and to maintain production at a high level, it is good hospital laundry practice to put one or two loads of flatwork through the washer the first thing in the morning.

LOCATION

In a study of 50 hospitals built since 1940, the principal governing factor of the hospital location seems to be proximity to laundry chutes and to elevators in contrast to hospitals built before 1920 where the governing factor was proximity to the boiler plant. Years ago it was felt important to situate the hospital laundry away from the hospital because of objectional odors and noise. The equipment manufactured today has greatly eliminated the noise factor and mechanical ventilation has overcome the objection of odors.

Cost studies of laundries have indicated that one of the most expensive single items is the distribution of clean linens. This varies

Mr. Steinle is hospital program director, Federal Security Agency, United States Public Health Service, New York City. This article is adapted from an address given at the American Hospital Association's Laundry Institute, December 1952, in Detroit.

from 10 to 40 per cent of the total laundry cost. This makes the problem of the location of the laundry a comparatively simple one. It has to be in or immediately adjacent to the hospital to avoid long lateral transportation problems. Some modern hospitals are providing large automatic dumbwaiters to assist in the distribution of clean linens.

WORK FLOW

Modern laundry equipment must be supplemented by proper working conditions and good plant layout. Gravity flow is the most economical medium available for work flow. Conveyors are much more economical than manpower. In a 200-bed hospital with 21,000 pounds of laundry per week someone must be paid to collect and transport the 21,000 pounds from the collection points to the laundry, through the various operations —soiled linen room, sorting rooms, washing, extracting, flatwork ironing, drying, pressing, assembling— and back to the delivery point. Thus it is necessary to pay for hauling 42,000 pounds of laundry each week, not 21,000 pounds, because it must be carried from the collection points and returned to the collection points. Every time the distance between any of these operations can be shortened, a substantial saving in payroll money can be effected.

In the past 10 years, more and more laundries have assumed the responsibility of linen distribution to the floors. This seems to be almost a trend. The laundry manager and the housekeeper must concern themselves more and more with the problem of linen control and redistribution. Consequently there is a greater pressure on the part of the laundry administrator to avoid long cartage between the laundry and the source of vertical transportation.

Some hospitals have as part of the laundry activity the preparation of "bed packs." This is a laundry set which is delivered to the floor and includes necessary bed linen for a complete change, patient's face and bath towels and wash cloth. Additional space in the linen storage room for making up the bed packs is required.

In hospitals of 200 beds or more, the ideal laundry system is a two-level unit with the upper floor having the linen intake, the sorting, counting and loading of the washer. The washing, extracting, ironing, pressing and clean linen storage is on the lower floor. The most time-consuming and consequently expensive single operation in the laundry is the loading of the washer. The gravity load from the upper floor greatly simplifies this activity. A two-floor laundry is not practical in smaller laundries (generally less than 200 beds) where employees are required to do a wider range of work, and for maximum flexibility all activities should be done on one floor.

Whether or not the laundry is to be responsible for the collection of soiled linen either on the floor or from the chutes and whether or not it is to have the responsibility for the storage and distribution of the clean linens must be determined before the laundry can be designed.

The location of the laundry is important not only for simplicity of intake of dirty linen and distribution of clean linen but also from the standpoint of personnel. A comparison was made between two hospitals of approximately the same size, one where the laundry was located 200 feet from the main building and the other where the laundry was in the hospital proper. It was found that 15 minutes more per laundry employee per day were lost in going to the hospital and returning to the laundry than where the laundry was in the hospital building. The time loss included the putting on of overcoats and often the stopping enroute to and from the laundry.

A danger in placing the laundry in the main hospital building is the tendency by so many planners to put it in the basement or sub-basement. A study of 20 hospital laundries situated in basements and 20 comparable laundries placed above ground indicated that the personnel turnover was approximately 12 per cent higher annually in the facilities where the laundry was below ground.

When the laundry is placed in the basement, often the waste must be pumped up to the sewer. This creates not only a danger in back siphonage but also is an added cost.

CONSTRUCTION

Structural floor slabs in the laundry should be designed for a live load of 150 pounds per square foot. The ceiling height should not be less than 11 feet. A greater height, usually a minimum of 15½ feet, will be necessary if a monorail system is used for handling the extractor baskets. The walls may be of concrete masonry units or glazed tile. If plaster is used, it should be cement plaster. Masonry and cement plaster should be painted with light colored, waterproof, flat paint.

Gutters from the washers should connect with six-inch drains. They should be provided with movable strainers to catch the lint. Extractors should be connected to drain-lines rather than to washer gutters. The extractors should be isolated from the structural frame to prevent sound and vibration from being transmitted to the other parts of the structure. A heavy concrete base flush with the floor on a bed of sand with two-inch cork on all sides has proven satisfactory for sound and vibration insulation. All machines should be firmly anchored to the concrete slab. Those in which vibration is to be expected should be provided with separate isolated machine foundations similar to those provided under the extractors.

The finished floor may be either of concrete or quarry tile pitched to strategically placed floor drains. Duck boards have been found to be hazardous and their use should be avoided.

Fixtures should be vapor-proof and so located as to provide 15 foot-candles over the general laundry area. The pressers and ironers should be provided with 20 foot-candles. The sorting and counting area should have 20 foot-candles.

VENTILATION

The primary purpose of the ventilating system for the laundry is to remove vapor and heated air from the ironer, presses and washers. At least 50 per cent of the air should be taken from a hood over the ironer. The quantity exhausted

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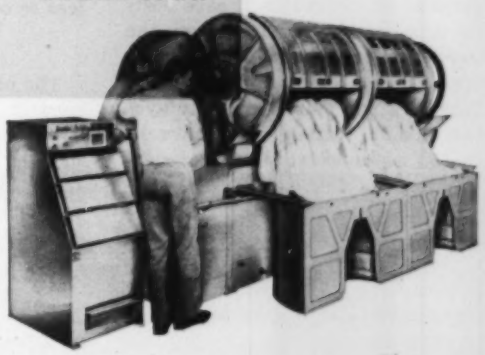

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varies with the size of the machines and the natural ventilation of the room. For a 100-bed hospital, the exhaust required from the ironer is approximately 2,500 C.F.M. This air should be taken from a hood with hinged glass panels mounted directly over the ironer. An additional exhaust, equipped with a lint catcher, must be connected with the tumbler to carry air from the fan to the roof.

Exhaust should be at a point well above the roof where it will not be blown into the windows of the hospital or adjacent buildings. In cold climates, double window glass should be used to prevent condensation.

HEAT

More and more hospitals are reclaiming heat from the waste water. In this system the waste water is run from the washer to a reclaiming tank. Intake water is run through coils in the tank. In this way, if the waste water is 160 degrees, intake water of 35 degrees is raised to a temperature of 105 degrees. It is then boosted either by live steam introduced into the washer or by a hot water tank. This tank can be gas heated or have live steam introduced.

Steam for the flatwork ironer should be 125 pounds at the machine. Steam pipes should be welded. Extra heavy steel or wrought iron pipe should be used for laundry piping. Each riser and each piece of equipment should be valved separately to permit repair and replacement.

WATER

The optimum water pressure for the laundry is 45 pounds. A simple balancing tank may serve where the water pressure is low for short periods. At times it will save costs to supply the laundry from the street main and pump water to the upper floors or to a gravity tank. Where a public water supply system is not available, water wells should be considered for continuous supply in preference to the use of surface water requiring a treatment plant and continuous supervision. In all cases involving other than public water supply, the state health agency should be consulted.

The use of hard water requires excessive soap. If the hardness exceeds four grains per gallon, it is usually more economical to operate a water softening plant than to use the excessive soap required. The local laundry can usually furnish reliable data on the treatment, if any, that will be advisable. If zeolite is employed in softeners to remove the calcium from the water, a storage space will be required for the considerable salt used in the removal of the calcium, which is deposited on the zeolite. Removal is accomplished by washing with salt water. The softener should be separately closeted to avoid unnecessary corrosion to metals by zeolite.

Hot water should be 180 degrees in the washer. The pipe lines to and from washers should be from 2 inches to 4 inches depending upon the size of the equipment.

Two water services should be brought into the building from two street mains, where available, to provide an emergency service in case one main fails. All water supply connections should be made above the rim or highest water level to provide an air gap so that back siphonage cannot be established. Recommendations for air gaps at water supplies and for back flow prevention are discussed in Report BM 28 of the National Bureau of Standards. By providing meters on the water main from the street and on cold water connections to the water heater serving the laundry, a satisfactory check can be made of the water consumption. Tubs should be equipped with the heaviest line of brass faucets available. Each plumbing fixture and each piece of equipment should have built-in stop valves to permit repairs or replacement of washers without disrupting services to other fixtures.

PIPE LINES

The pipe lines to the washers are usually 2 to 4 inches. The sewerage required for a laundry will vary by size of load. The following is given as a schedule for daily poundage:

..... to 1,200 lbs.	4" line
1,200 to 2,000 lbs.	5" line
2,000 to 5,000 lbs.	6" line
5,000 to 9,000 lbs.	8" line

Occasionally where the laundry is located in the basement, the waste must be pumped up to the sewer. This procedure should be avoided if at all possible.

GAS

Small laundry plants (less than 1,200 daily poundage) often have gas heated instead of steam equipment. Such equipment may be provided in two ways:

1. Heat chest for the individual piece of equipment, usually the flatwork ironer, or,

2. As small boilers used exclusively for the laundry.

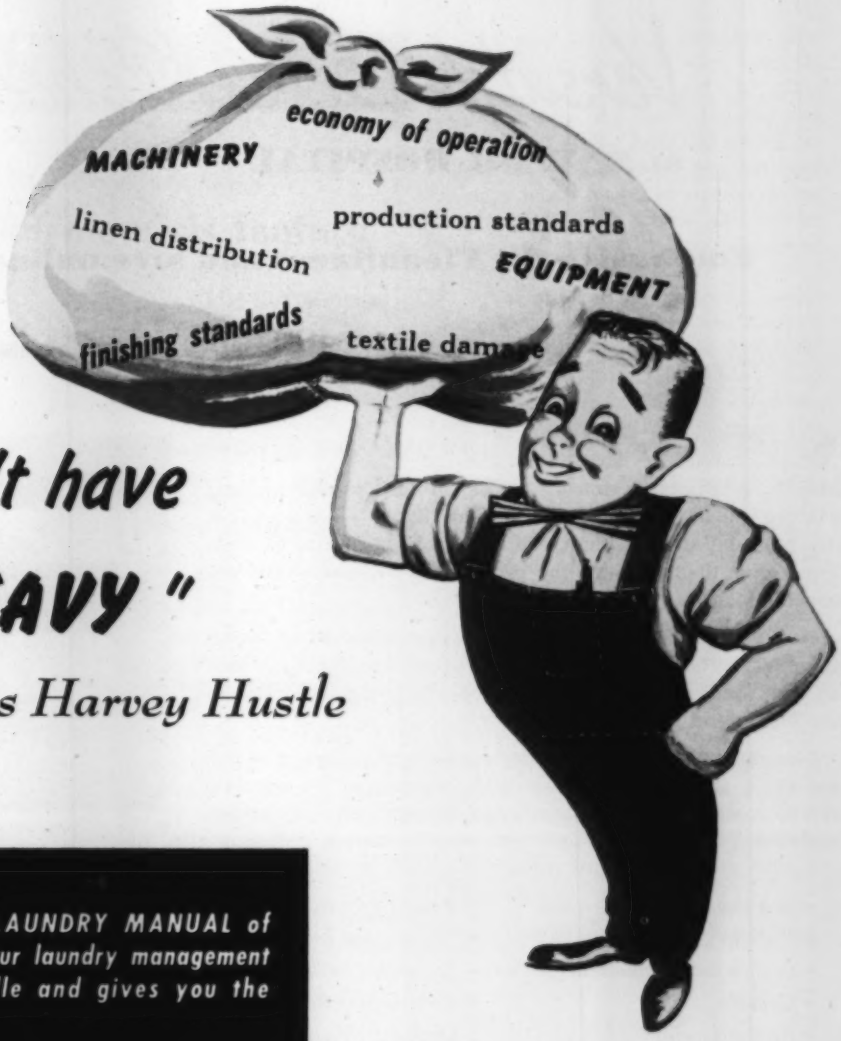
Both systems are expensive to operate and should not be used in larger programs. The heat chest and gas boilers take up space and are often hazardous to personnel.

Hospital laundry planning has been so inadequate that the average hospital has not been properly planned for current needs, let alone providing for technical changes and increase in size of the hospital. Consequently, a large number of hospital laundries are obsolete the day they begin to operate. If we plan our hospital laundries to meet the critical requirements of the heaviest day load for present operations, it is much easier to meet increased demands and keep the laundry modern by administrative provisions. Some of these provisions are:

1. *Distributed load* — With increased linens and storage space, the hospital can shift to a distributed load. That is, the maximum two-day accumulation for Monday can be distributed through the week. This will provide approximately a 20 per cent increase in output.

2. *Double shifts* — Some hospital laundries, like industry, have found it necessary to have double shifts to increase production.

3. *New equipment* — Often new equipment can be obtained to increase production with increased load. Occasionally a piece of equipment may be justified for a large load where it is not economically feasible in a smaller plant. The automatic sheet folder is an example of this. Advancement in equipment over the past 20 years has increased laundry productivity from 20 to 30 per cent without increasing the space requirements.



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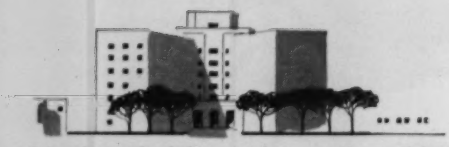

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- Twin-type coffee urns
- Deep-fat Fryers
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Modified diet manuals feature helpful tips for dietitians

THREE MANUALS have recently been published on the feeding of the elderly person, the patient with heart disease, and the person requiring a high-protein diet. The following digest and reviews of the manuals have been prepared to present the dietitian in the general hospital with some helpful tips on food preparation for those patients.

Food for geriatrics

"EATING IS FUN . . . for older people, too," when their meals are well-planned, adequately prepared and promptly served. In a 17-page booklet with the same title,* the American Dietetic Association has published some helpful hints on meal planning, preparation, and service for dietitians of small homes for the aged and proprietary nursing homes. Although the pamphlet was directed to that group of dietitians, the following tips on food preparation are applicable to the dietitians in a general hospital in planning meals for the elderly patient on a normal diet.

PLANNING TIPS

1. How to plan: Preparation of meal and marketing plans are the first two steps in food preparation. Advance planning saves time and money, insures a more cooperative working staff, and assures the patient of the best food. When the menus are written out, the planner can easily study each meal pattern for variety in color, flavor, texture, and temperature and readily check the daily menu against the Basic Seven.

The weekly marketing plan has been found to be both economical and time saving. The accompanying table shows the weekly quantities of food which the American Dietetic Association recommends for each elderly patient.

When ordering supplies, substitute less expensive foods for the more costly items. For example, purchase six tall cans of evaporated milk or one pound of nonfat dry milk plus one-half pound of fortified margarine in place of five quarts of whole milk.

Buying in quantities is another economical purchasing measure. Buy frozen foods in five and ten-pound packages. If 25 to 30 are to be served, Number 10 cans are cheaper than the smaller ones. Salad dressing, catsup, mustard, and pickles may be bought cheaply in gallons or in Number 10 cans. Fresh fruits and vegetables are most economical by the crate or hamper, peck or bushel.

2. What to plan: Attractice, nutritious meals with variation in temperature, texture, and color are the goal of every dietitian. Prepare three meals a day with the main meal at noon and also allow for snacks. An older patient long confined to the hospital would especially enjoy short periods each day; when he could sip tea or hot chocolate with fellow patients on the sun parlor or special dining room on the wing.

Variation in temperature means both hot and cold course at each meal with at least one hot dish. Although elderly people need foods easy to chew, mashed potatoes and mashed rutabagas at the same meal indicate absence of contrast in the texture of the food. Instead of another smooth texture food, prepare carrot strips or celery sticks. Pickled beets and sauerkraut are not companion vegetables, but a small serving of pickled beets is second cousin in flavor to macaroni and cheese with green peas. Chilled salmon and stewed tomatoes indicate monotony of color in the meal; while the fish entree with buttered green beans is an eye-catcher. Older people enjoy surprises; so avoid serving cheese souffle every Friday or stew from left-overs every Saturday.

PREPARATION TECHNIQUES

1. Vegetables: Brown-tinged spinach and darkened cauliflower show the vegetables have been cooked in the wrong manner. Cook fresh green and strongly flavored vegetables without a cover. Frozen vegetables need a cover with the exception of corn on the cob and spinach. In cooking all types of vegetables a small amount of water is advisable. To insure retention of color and nutritive value, remove vegetables from the

Weekly quantities of food for the elderly patient

	Per Person Per Week
Green and yellow vegetables	2½ lbs.
Citrus fruit or juice	2¼ lbs.
Potatoes (white or sweet)	2½-3 lbs.
Other fruits and vegetables	2½ lbs.
Milk	5 qts., 6 cans evap. milk, or 1 lb. dry nonfat solid plus ½ lb. fortified margarine
Lean meat, fish, chicken, or cheese	2¾ lbs.
Eggs	4, prefer 7
Dried beans, peas, or peanut butter	2 oz.
Whole grain and enriched cereals	2¼ lbs. (women) 3¼ lbs. (men)
Margarine, butter, fat meat, cooking fats, mayonnaise	½-¾ lb.
Sugars, syrups, and preserves	½-¾ lb.

*Copies of "Eating is Fun" may be obtained by writing to the American Dietetic Association, 620 N. Michigan Ave., Chicago 11. Price is 50 cents a copy.

steamer or stock kettle immediately.

2. Meat: A rolled beef roast is too expensive these days to let it shrink greatly by using a high cooking temperature. A low temperature should be used in meat cookery regardless of the method.

For a pot roast or other less tender cut of meat, choose the braising method of meat cookery. The addition of liquid softens the connective tissues and prevents the meat from becoming dry and hard during cooking. For that Sunday dinner of roast veal, roast the leg of veal in a shallow roasting pan in a slow oven (300°).

SERVICE TECHNIQUES

1. Dining room: Most older patients prefer coming to the table to eat; so they can eat together as members of a family. The booklet points out that eating family style makes them less hesitant about asking for second helpings and more likely to eat foods they would refuse when eating alone.

If there are adequate facilities, a combination of table and tray service may be employed. A tray is brought to the patient in the morning and in the evening; while he comes to a central dining room for dinner.

2. Tray: Where tray service is the sole means of food service, special care needs to be taken for the manner in which the tray is set. A fresh flower or tray favor brings cheer to the patient.

• • •

High protein diets

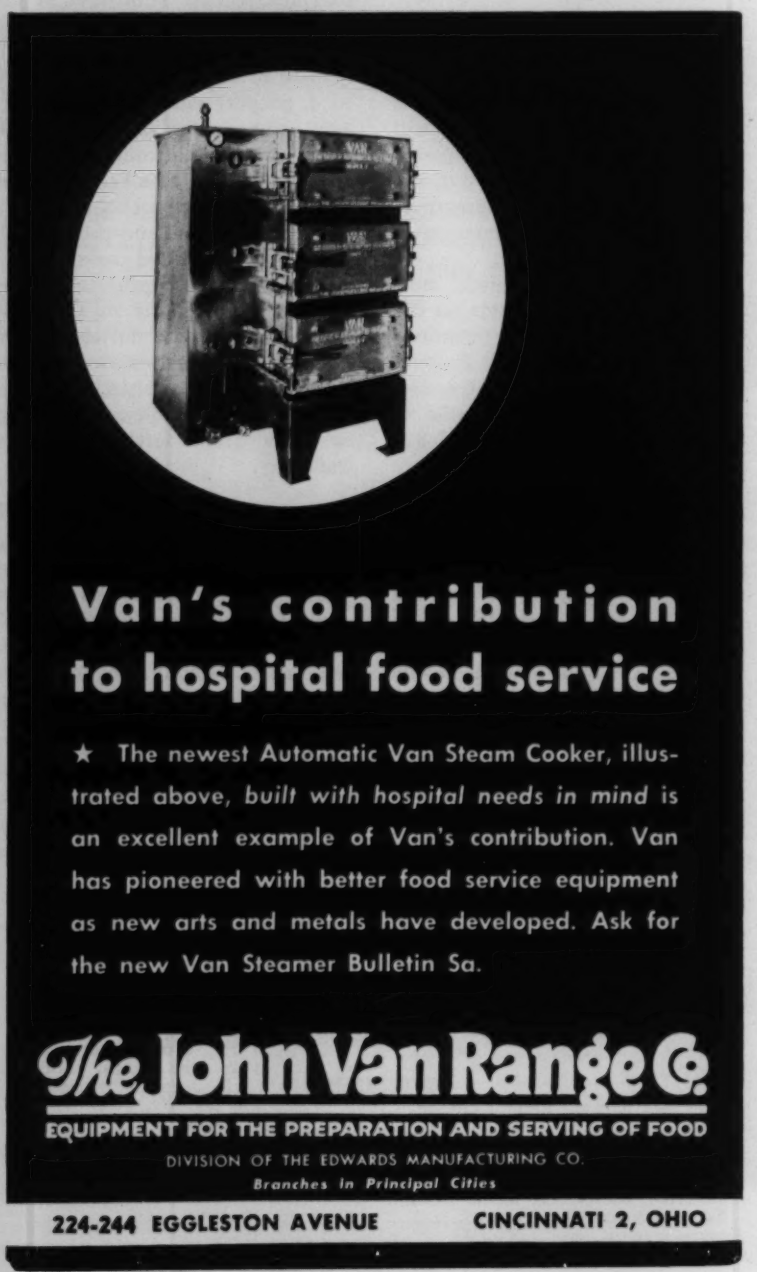
"Recipes and Menus for High Protein Feeding," a new publication of the U. S. Army Medical Nutrition Laboratory, Chicago, contains a large number of fortified recipes and general non-fortified recipes for inclusion on high protein diets.

The publication is unique in several ways. Jane R. Spinella, who prepared and tested the recipes, has calculated a percentage basis for each ingredient. This simplifies adjusting recipes, if fewer or more than the basic 50 portions is desired. Proportions also have been given by weight and standard measurements.

Another feature unique to this new publication is the use of natural protein fortification of animal origin such as nonfat dried skim milk solids, whole fresh fluid milk, whole eggs, egg white, egg yolk and canned junior and strained meats. For example, the recipes for gingerbread on page 51 and chocolate icebox cookies on page 88 are fortified with strained veal.

A calcium caseinate concentrate is used to fortify other foods. In many recipes containing this concentrate, the method of mixing is exteremely important and very often is radically different from the normal pattern.

The Dietetics Administration department is edited by Mrs. Isola Denman Robinson, dietetics specialist.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★ The newest Automatic Van Steam Cooker, illustrated above, built with hospital needs in mind is an excellent example of Van's contribution. Van has pioneered with better food service equipment as new arts and metals have developed. Ask for the new Van Steamer Bulletin Sa.
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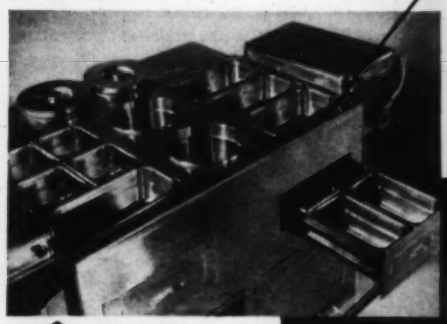
one food conveyor gives you dozens of inset arrangements for your selective menus

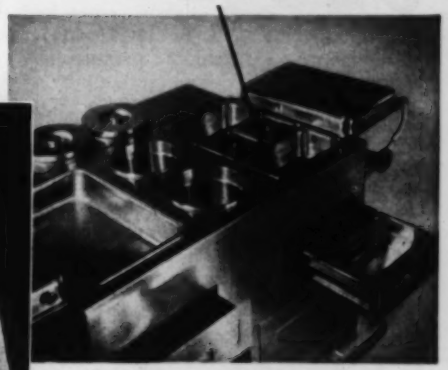
This new electrically-heated food conveyor is designed specifically for selective menus. It will contribute to successful diet-therapy in your hospital. Eighteen insets in various sizes can be placed in the wells in different combinations. These provide innumerable top deck arrangements to meet the requirements of any given meal. In addition to the two rectangular wells, there are two round wells for soup and broth and two heated drawers for special diets and rolls. The entire unit is made of heavy-gauge corrosion-resistant stainless steel. Top and body are of seamless, crevice-free construction, meeting the strictest hospital standards for sanitation and durability. If you're contemplating the "selective menu" idea, write for information about Model ALS-4922.

▲ EIGHTEEN square and rectangular stainless steel insets in various sizes can be arranged in many combinations.

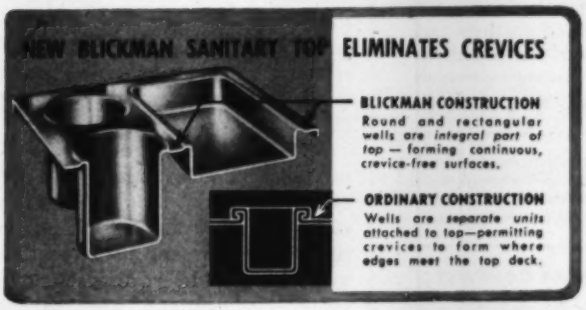


▲ *Above:* Today's menu may call for four square and four rectangular insets as shown here

Right: While tomorrow, square and rectangular insets may be arranged like this. ▶



▲ *Above:* Still another arrangement is shown. Note the heated drawers and the convenient serving shelf.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Recipes selected for fortification were those from dishes commonly served in hospitals, which were generally acceptable to the patient. The variety of recipes in 19 categories demonstrates the extensiveness that can be achieved. The recipes have been tested for continued acceptability by hospital patients.

The recipe forms were set up to include the following: Title of dish, type of recipe, type of fortification, type number, and size of pans, size of portion, yield, the percentage basis, the weights and measures of ingredients, and the method of preparation. In many of the recipes where mechanical mixers are used, the mixing speed and time are indicated.

For each of the 14 daily high protein menus there is a table of calculated nutritive values before cooking. Included also is a conversion table from grams to pounds and tables of weights and measures for individual foods used in the fortified recipes.

The author points out that "the need of high protein consumption by a patient suffering from disease has been recognized by many authorities in the field of medicine; certain diseases requiring more protein than others."

Pertinent and valuable references are given in the manual's bibliography.

"Recipes and Menus for High Protein Feeding" may be secured by writing to the Medical Nutrition Laboratory, United States Army, 1819 West Pershing Road, Chicago 9.

• • •

Feeding heart patients

FOOD FOR YOUR HEART. A Manual for Patient and Physician. New York City American Heart Association, 1952. 48 p. 25 cents.

THIS NEW PUBLICATION was prepared by the staff of the Department of Nutrition, Harvard School of Public Health. Dr. Frederick J. Stare, chairman of the department, headed a special committee of the American Heart Association composed of authorities in the field who supervise the preparation of the manual.

This complete low-priced handbook, which incorporates nine diets, sample menus and the latest information on nutrition and heart disease, is planned to help the heart patient enjoy his food despite dietary restrictions.

Pointing out that "many physicians and scientists consider nutrition the most important environmental factor in health," the manual dispels many misunderstandings about reducing and modified diets and makes clear the reason why only physicians should prescribe such diets for patients.

Endorsed by the American Medical Association's Council on Food and Nutrition, the new guide states that proper diet counts in the prevention and treatment of many kinds of heart disease and of some complications, such as the accumulation of excess fluid in the body tissue (edema). How blood

If you want better cooking at lower cost —you want *steaming!*

Labor comes high these days. Food itself comes high. The food service operator is caught in this double pressure.

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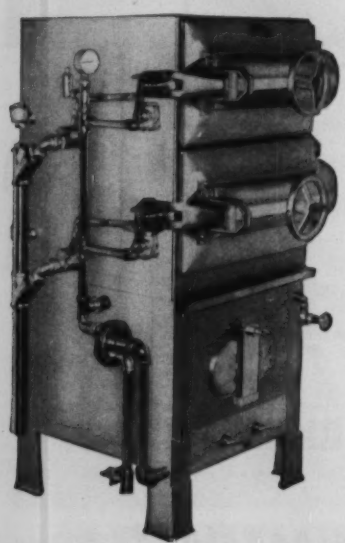

Now more than ever, when every cent of kitchen economy is vital, steaming is just *common sense* in any kitchen, large or small. Let us tell you more about it. Our booklet, "For Better Steaming" gives the how and why.

Steam-Chef standard steamers are made with 2, 3, or 4 compartments. Steamcraft Junior models are made with 1 or 2 compartments, for counter or table use or mounted on their own bases. All models are furnished for direct steam, gas or electric operation. Write for full details.

"THE WINNER" Educational 24-minute sound, color movie. Gives dramatic steam cooking demonstration. Available on request for showing to groups.

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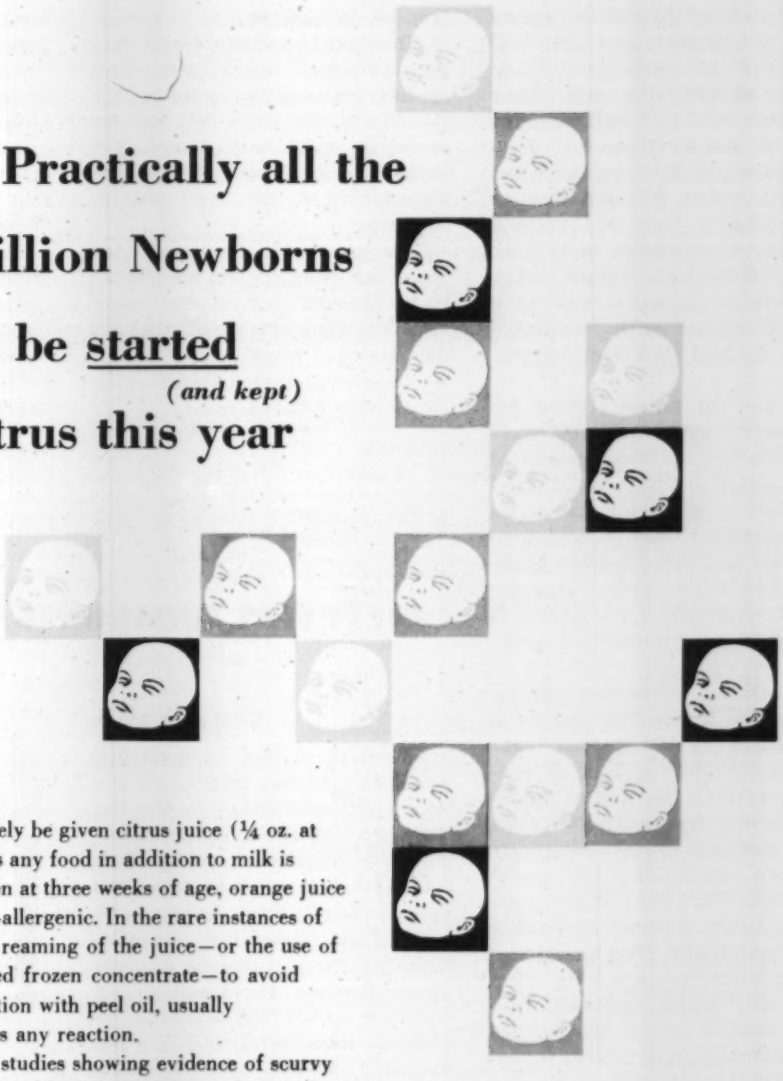
Practically all the 3.5 Million Newborns can be started *(and kept)* on Citrus this year



Newborns can safely be given citrus juice (¼ oz. at first) as soon as any food in addition to milk is permitted. Even at three weeks of age, orange juice is virtually non-allergenic. In the rare instances of sensitivity, gentle reaming of the juice—or the use of specially prepared frozen concentrate—to avoid contamination with peel oil, usually obviates any reaction.

With postmortem studies showing evidence of scurvy ten times as frequently as it was observed clinically, more than ever it is apparent that children must be guarded vitamin C-wise to insure adequate growth and development.

FLORIDA CITRUS COMMISSION • LAKELAND, FLORIDA

FLORIDA *Citrus*

ORANGES • GRAPEFRUIT • TANGERINES

pressure, or hypertension, is a common cause of heart disease and is often treated by dietary measures. The manual makes clear that "neither a low sodium diet nor weight control nor any other treatment should be considered a cure for heart disease or high blood pressure. No cures have yet been discovered. But diet therapy will probably help the patient, especially when started early. Low sodium diets have helped many hypertensive patients and have enabled others with weakened hearts to lead full and happier lives."

No one yet knows, "Food for your Heart" points out, why overweight favors the development of heart disease and high blood pressure. But it is known that extra pounds mean a heavier burden on the heart and blood vessels. Many physicians think removing excess weight, even when no disease is present, is good preventive medicine.

A plan for converting regular recipes into low sodium recipes is included in the diet manual, making the housewives task of preparing food for the entire family easier. Because patients often complain that low sodium diets are dull and unpalitable, the menus in "Food For Your Heart" are imaginatively planned to counter these complaints. They prove that with the use of seasoning other than salt, which contains very little sodium, meals can be not only palitable but interesting as well.

The manual is tab-indexed for quick reference. Desirable weights and how to reach them, cholesterol and heart disease, sodium and heart disease, and general dietary principles are discussed. Low sodium diets are so arranged in the manual that the physician has only to mark the diet he wishes the patient to follow, and to indiciate the list of foods from which the patient may choose for the day. These foods are listed according to weight and composition, fat, carbohydrates, and protein content, as well as varying levels of sodium restriction so the physician will have no difficulty in making quick adjustments in the patient's diet if he so desires. A pocket in the inside cover may be used by the physician for additional instructions to the patient.

While the American Heart Association does not endorse any specific low sodium foods or salt substitutes, the book lists for the convenience of both doctor and patient, a number of national manufacturers of low sodium products.

The patient is reminded that there are other sources of sodium to be checked such as city water supplies. They are urged to check medications, tooth paste, mouth washes and processed food, as well, for sodium content.

The need for the new comprehensive handbook was indicated, the manual points out, by the popularity of the "Cookbook for Low Sodium Diets," prepared in 1950 by the Massachusetts Heart Association, which was "well received among the medical profession." Many of the recipes and tables in that booklet are incorporated in "Food For Your Heart."

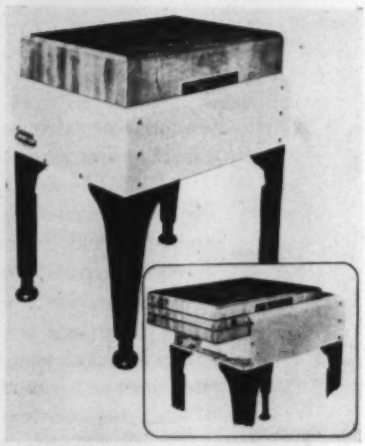
The manual may be obtained by laymen from affiliated heart associations only on doctors prescriptions at 25c per copy. It will, however, be distributed to physicians, nutritionists, nurses, dietitians, health departments and hospitals.

DIETETICS ADMINISTRATION COMMENT

Chopping block

Described as the "greatest improvement in chopping block design and construction in the last 65 years" is the recently introduced reversible chopping block (2D-1).* It is a combination unit of permanent steel fixture with removable, reversible chopping block which is surfaced on both sides. Because the block is reversible, service life is greatly increased. Resurfacing will be a less frequent process. No expensive installation is required and it features adjustable-height legs.

The block itself is deeply grooved to slide in and out of the fixture like a drawer so that reversal or exchange can be accomplished quickly and easily. Another advantage claimed for the block is that the steel fixture is a one-time investment and only the block need be replaced. In addition, hospitals can buy just the fixtures and have present blocks reconditioned and converted to fit. It is available in a complete range



of sizes from 6 to 12 inches in depth and from 18 x 18 inches to 35 x 70 inches in diameter.

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

Soup-a-day plan

A soup-a-day plan consisting of seven basic soups in dehydrated form and three alternates is now on the market (2D-2).* The manufacturers of these soups require them to pass approval by a panel of executive chefs from leading hotels. Three major qualifications which soup must pass are 1) quality and dietary values plus taste properties of the various ingredients, 2) ease of preparation

in the kitchen, plus formulations varying from one to 16 gallons or more and 3) economy of cost based upon an eight ounce serving per customer of the institution.

The ten soups are beef vegetable noodle, chicken noodle, clear beef broth, clear beef vegetable, clear chicken broth, French onion soup and French potato soup. The alternates are chicken vegetable, chicken vegetable noodle, and pea soup. According to the manufacturer the French style potato soup is the only one of its kind on the market to date.

The product comes in glass jars with complete directional labels and identification on each jar. The standard pack comes in multiples of six, 12 and 24 jars per case. With the exception of clear beef broth and clear chicken soup which come put up in four-gallon and 32-gallon batches in cans, all others come put up for one, two and four-gallon batches.

Master Menus for March

THE MASTER MENUS for March 1953 include suggestions for standardized tested recipes each day. These recipes which are available in "Large Quantity Recipes" by Margaret E. Terrell are easy to use both in the food preparation and in cost accounting as the ingredients are stated in both volume and weight. A general and seven modified diets are provided in the menu plan.

These menus reduce to a minimum the number of diets, simplify planning, decrease costs and conserve food preparation time. The general diet forms the basis of the seven most commonly used modified hospital diets. Selections to be served on the general diet are set in boldface type in the Master Menus.

Modified diets in the menu plan are the soft, full liquid, high protein, high calorie, low calorie, low fat and measured or weighed. All except the full liquid diet have been planned to include the nine food essentials and servings required for nutritional adequacy. The menus are adaptable for selective service.

Consideration is given in planning to flavor, variety, attractiveness and general acceptance by patients. Color is a factor, and color combinations must harmonize. Foods in each meal are planned in a variety of forms, not all flat, high, or round but a pleasing combination of shapes.

Master Menu Kits containing the revised wall cards, sample transfer slips and the "Master Menu Diet Manual" are available to users of the menus. The kits are priced at $2 and may be secured by writing the Editorial Department of HOSPITALS. Single copies of the manual may be purchased for $1.50.

Summary of dinner meats

Dinner Meats	*Dates on menu*	*Total*
Beef	Mar. 2-12-16-19-24-29	6
Veal	Mar. 5-11-17-23	4
Lamb	Mar. 10-28	2
Pork	Mar. 3-9-14-21-26-30	6
Liver	Mar. 7-25	2
Poultry	Mar. 1-8-15-18-22-31	6
Fish	Mar. 4-6-13-20-27	5
		31

Full directions for using the Master Menu are in the manual and information on preparing 15 other modified diets with the aid of the menus.

March 1

1. **Grapefruit juice**
2. Grapefruit juice
3. **Oatmeal or crisp rice cereal**
4. **Soft cooked egg**
5. Bacon
6. **Corn muffins** (‡ 69)

7. **Consomme**
8. **Melba toast**
9. **Turkey a la king on Holland rusk**
10. Hot sliced turkey
11. **Glazed sweetpotatoes**
12. Riced potatoes
13. **Green beans**
14. Green beans
15. **Sliced orange and stuffed date salad**
16. **Cream mayonnaise**
17. **Vanilla ice cream**
18. Vanilla ice cream
19. Orange ice
20. Orange cup
21. Blended citrus juice

22. **Oyster stew** (‡ 45)
23. **Oyster crackers**
24. **Grilled cheese sandwiches**
25. Minced beef—peas
26. Cold roast beef—peas
27. Baked potato
28. ———
29. **Tomato and cress salad**
30. **Russian dressing** (‡ 243)
31. **Peach and raspberry compote—angel food** (‡ 275)
32. Canned peaches—angel food
33. Cherry sponge
34. Unsweetened canned peaches
35. Pineapple juice
36. ———

March 2

1. **Orange halves**
2. Orange juice
3. **Corn flakes or rolled wheat**
4. **Scrambled egg**
5. Grilled turkey livers
6. **Toast**

7. **Beef bouillon**
8. **Saltines**
9. **Country fried steak**
10. Broiled steak
11. **New potatoes in cream sauce**
12. New potatoes
13. Scalloped corn (‡ 201)
14. Quartered carrots
15. **Tossed salad**
16. **French dressing**
17. **Gingerbread with whipped cream** (‡ 266)
18. Chocolate pudding with whipped cream (‡ 336)
19. Whipped cherry gelatin
20. Unsweetened canned boysenberries
21. Grapefruit juice

22. **Turkey soup**
23. **Crisp crackers**
24. **Chicken chow mein on rice with crisp noodles**
25. Baked veal patties—chopped spinach
26. Baked veal patties—chopped spinach
27. Baked noodles in broth
28. ———
29. **Romaine and beet salad**
30. **Piquante dressing** (‡ 242)
31. **Fresh pineapple cup—chocolate chip cookies** (‡ 292)
32. Tinted pear and rice compote
33. Chocolate pudding
34. Fresh pineapple
35. Apricot nectar
36. **Parker house rolls**

March 3

1. **Grapefruit**
2. Blended citrus juice
3. **Crisp rice cereal or hominy**
4. **Soft cooked egg**
5. Bacon
6. **Cinnamon toast**

7. **Vegetable soup** (‡ 34)
8. **Crisp crackers**
9. **Baked glazed Canadian bacon**
10. Roast lamb
11. **Baked sweetpotato**
12. New potatoes
13. **Kale with lemon or spinach**
14. Diced summer squash
15. **Banana and cherry salad**
16. **Cream mayonnaise**
17. **Peppermint stick ice cream**
18. Peppermint stick ice cream
19. Lime ice
20. Unsweetened Royal Anne cherries
21. Orange juice

22. **Corn chowder** (‡ 41)
23. **Saltines**
24. **Open hamburger steak sandwich—cole slaw**
25. Chopped beefsteak—peas
26. Chopped beefsteak—peas
27. Riced potatoes
28. ———
29. **Sliced tomato salad**
30. **French dressing**
31. **Pear and apricot halves—oatmeal cookies** (‡ 302)
32. Canned peeled apricots
33. Baked custard
34. Unsweetened canned apricots
35. Pineapple juice

‡ Arabic numerals indicate page on which recipe may be found in "Large Quantity Recipes," by Margaret E. Terrell, Philadelphia, J. B. Lippincott. $7.

36. ———

March 4

1. **Orange juice**
2. Orange juice
3. **Rolled wheat or corn flakes**
5. Bacon
6. **Toast**

7. **Beef noodle soup**
8. **Saltines**
9. **Meat or tuna pie with peas, biscuit topping** (‡ 175)
10. Broiled perch fillets
11. ———
12. Potato balls
13. **Sliced new beets**
14. Sliced new beets
15. **Stuffed prune salad**
16. **French dressing**
17. **Apple crisp with whipped cream** (‡ 347)
18. Sliced pear gelatin with whipped cream
19. Orange gelatin cubes
20. Orange and banana cup
21. Grapefruit juice

22. **Cream of tomato soup** (‡ 49)
23. **Croutons**
24. **Potato salad on lettuce—deviled eggs** (‡ 230)
25. Cottage cheese
26. Cottage cheese
27. Stuffed baked potato
28. **Asparagus tips**
29. **Carrot sticks**
30. ———
31. **Jelly roll** (‡ 276)
32. Royal Anne cherries
33. Vanilla blanc mange
34. Unsweetened pear and plum compote
35. Fruitade
36. **Bread**

March 5

1. **Tomato juice**
2. Tomato juice
3. **Wheat and barley kernels or farina**
4. **Scrambled egg**
5. Link sausages
6. **Toast**

7. **Beef bouillon**
8. **Crisp crackers**
9. **Roast leg of veal with dressing**
10. Roast leg of veal
11. **Oven browned potatoes**
12. Steamed potatoes
13. **Diced celery and pimiento**
14. Green beans
15. **Orange slices on endive salad**
16. **Diced avocado dressing**
17. **Raspberry sherbet**
18. Raspberry sherbet
19. Raspberry ice
20. Half grapefruit
21. Blended citrus juice

22. **Cream of mushroom soup** (‡ 45)
23. **Saltines**
24. **Spanish rice** (‡ 111)
25. Crisp bacon
26. Cold roast lamb
27. Rice with tomato puree
28. **Spinach with lemon**
29. **Celery sticks**
30. ———
31. **Fresh pineapple cup**
32. Canned peaches
33. Cherry gelatin
34. Fresh pineapple cup
35. Grape juice
36. **Blueberry muffins**

March 6

1. **Orange slices**
2. Apricot nectar and lemon juice
3. **Oatmeal or crisp rice cereal**
4. **Poached egg**
5. Bacon
6. **Wheat muffins**

7. **Clam chowder** (‡ 38)
8. **Oyster crackers**
9. **Golden brown flounder fillets—tartar sauce** (‡ 185)
10. Broiled flounder fillets
11. **Fluffy mashed potatoes**
12. Riced potatoes
13. **Frozen lima beans**
14. New beet greens
15. **Tossed salad**
16. **Vinegar-oil dressing**
17. **Strawberry shortcake**
18. Sliced banana in orange juice
19. Strawberry gelatin cubes
20. Strawberry and banana cup
21. Limeade

22. **Cream of spinach soup** (‡ 49)
23. **Melba toast**
24. **Salmon timbales with mushroom cream sauce** (‡ 183)
25. Creamed salmon
26. Poached salmon
27. Baked potato
28. **Green peas**
29. **Grapefruit and red apple section salad**
30. **Fruit salad dressing**
31. **Cup cakes with coconut frosting** (‡ 264)
32. Prune whip
33. Vanilla rennet-custard
34. Unsweetened canned plums
35. Pineapple juice
36. **Bread**

March 7

1. **Blended citrus juice**
2. Blended citrus juice
3. **Puffed rice or rolled wheat**
4. **Soft cooked egg**
5. Bacon
6. **Toast**

7. **Vegetable soup**
8. **Crisp crackers**
9. **Braised liver** (‡ 135)
10. Pan-broiled liver
11. **New potatoes in cream**
12. New potatoes
13. **Whole kernel corn**
14. Spinach with lemon
15. **Cabbage and raisin salad**
16. **Sour cream dressing**
17. **Baked cherry rhubarb—crisp sugar cookies**
18. Apricot whip—sugar cookies
19. Cherry sponge
20. Fresh fruit cup
21. Grapefruit juice

22. **Cream of corn soup** (‡ 41)
23. **Toast sticks**
24. **Broiled ham—spiced peach—baked noodles**
25. Scrambled eggs and noodles—asparagus
26. Baked veal chop—stewed tomatoes
27. Noodles (omit on Soft Diet)
28. ———
29. **Asparagus salad**
30. **Vinaigrette dressing**
31. **Orange marmalade bread pudding**
32. Applesauce
33. Baked custard
34. Fresh apple
35. Mixed fruit juice
36. **Bread**

March 8

1. **Sliced banana**
2. Grapefruit juice
3. **Farina or shredded wheat**
4. Scrambled egg (omit on Normal Diet)
5. Link sausages
6. **Griddle cakes—syrup—sausages**

7. **Alphabet soup**
8. **Saltines**
9. **Roast duck or chicken with dressing**
10. Roast chicken
11. **Mashed potatoes**
12. Riced potatoes
13. **Sliced carrots**
14. Sliced carrots
15. **Molded ginger ale fruit salad**
16. **Cream mayonnaise**
17. **Coffee ice cream**
18. Coffee ice cream
19. Lime ice
20. Grapefruit and strawberry cup
21. Orange juice

22. Old-fashioned navy bean soup (‡ 37)
23. **Crisp crackers**
24. **Omelet—jelly**
25. Omelet—jelly
26. Omelet
27. Baked potato
28. **Green beans**
29. **Sliced tomato salad**
30. **Russian dressing** (‡ 243)
31. **Canned pears—date cookies**
32. Canned pears
33. Spanish cream with jelly
34. Unsweetened canned pears
35. Pineapple juice
36. **Toasted French bread**

March 9

1. **Orange halves**
2. Orange juice
3. **Corn flakes or brown granular wheat cereal**
4. **Poached egg**
5. Bacon
6. **Raisin toast**

7. **Julienne vegetable soup**
8. **Crisp crackers**
9. **Roast pork**
10. Broiled veal pattie
11. **Brown rice**
12. Brown rice
13. **Stewed tomatoes**
14. Green peas
15. **Waldorf salad** (‡215)
16. ———
17. **Pumpkin chiffon pie** (‡325)
18. Caramel cup custard
19. Strawberry gelatin
20. Unsweetened canned peaches
21. Grapefruit juice

22. **Potato soup**
23. **Saltines**
24. **Meat balls with brown mushroom sauce**
25. Minced beef
26. Broiled steak
27. Parsley potato balls
28. **Patty pan squash**
29. **Head lettuce salad**
30. **Blue cheese dressing**
31. **Pineapple, apricot and plum compote**
32. Canned peaches
33. Caramel cup custard
34. Unsweetened canned fruit cocktail
35. Grape juice
36. **Hot rolls**

March 10

1. **Fresh strawberries**
2. Apricot nectar
3. **Oatmeal or wheat flakes**
4. **Scrambled egg**
5. Grilled Canadian bacon
6. **Toast**

7. **Frosted orange juice**
8. ———
9. **Lamb and vegetable stew** (‡140)
10. Roast lamb
11. **Potatoes (in stew)**
12. Riced potatoes
13. **Broccoli**
14. Julienne beets
15. **Tomato salad**
16. **Mayonnaise**
17. **Graham cracker pineapple pudding** (‡371)
18. Creamy rice pudding
19. Pineapple whip
20. Fresh pineapple cup
21. Bouillon or orange juice

22. **Beef noodle soup**
23. **Whole wheat wafers**
24. **Chicken a la king on Holland rusks** (‡156)
25. Creamed chicken
26. Hot sliced chicken
27. Baked potatoes
28. **Sliced carrots**
29. **Pink grapefruit section salad**
30. **French dressing**
31. **Burnt sugar layer cake** (‡270)
32. Royal Anne cherries
33. Baked custard
34. Unsweetened canned cherries
35. Tomato juice
36. **Bread**

March 11

1. **Blended citrus juice**
2. Blended citrus juice
3. **Puffed wheat or farina**
4. **Poached egg**
5. Bacon
6. **Bran muffins**

7. **Consomme**
8. **Whole wheat crackers**
9. **Stuffed breast of veal or fish**
10. Roast veal or fish
11. **Oven-browned parsnips**
12. Paprika potatoes
13. **Green beans**
14. Straightneck squash rings
15. **Molded cranberry, apple and almond salad**
16. **Cream mayonnaise**
17. **Rhubarb cobbler** (‡353)
18. Chocolate pudding
19. Whipped lime gelatin
20. Unsweetened canned fruit cocktail
21. Grapefruit juice

22. **Scotch barley soup**
23. **Crisp crackers**
24. **Pear, pineapple, peach, fig and strawberry salad—cream cheese nut bread sandwiches**
25. Broiled chopped steak—asparagus
26. Broiled chopped steak—broiled tomato slices
27. Stuffed baked potatoes
28. ———
29. **Celery hearts**
30. ———
31. **Chocolate cream pie** (‡317)
32. Banana and orange cup
33. Chocolate pudding
34. Orange and strawberry cup
35. Apricot nectar
36. ———

March 12

1. **Sliced bananas**
2. Grapefruit juice
3. **Rolled wheat or crisp rice cereal**
4. **Soft cooked egg**
5. Link sausages
6. **Sweet rolls**

7. **Tomato juice**
8. ———
9. **Braised pot roast with vegetable gravy**
10. Pot roast of beef
11. **Mashed potatoes**
12. Riced potatoes
13. **Breaded eggplant**
14. Quartered carrots
15. **Endive and julienne beet salad**
16. **Fresh horseradish dressing** (‡240)
17. **Hot fudge sundae**
18. Canned peach with lemon ice
19. Lemon ice
20. Unsweetened canned peaches
21. Chicken broth or tomato juice

22. **Cream of mushroom soup** (‡44)
23. **Melba toast**
24. **Canadian bacon—split baked potato with thin cheese sauce**
25. Bacon—baked potato with cheese sauce
26. Broiled lamb chop
27. New potatoes (omit on Soft Diet)
28. **Fresh spinach**
29. **Sliced orange salad**
30. **Clear French dressing**
31. **Coffee gelatin with whipped cream**
32. Coffee gelatin
33. Coffee gelatin
34. Unsweetened canned boysenberries
35. Mixed fruit juices
36. **Hot biscuits with honey** (‡64)

March 13

1. **Grapefruit**
2. Orange juice
3. **Corn flakes or brown granular wheat cereal**
4. **Scrambled egg**
5. Bacon
6. **Hot cross buns**

7. **Clam chowder** (‡38)
8. **Oyster crackers**
9. **Pan-fried red snapper fillets—tartar sauce**

‡ Arabic numerals indicate page on which recipe may be found in "Large Quantity Recipes," by Margaret E. Terrell, Philadelphia, J. B. Lippincott. $7.

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10. Broiled red snapper fillets
11. **Scalloped potatoes**
12. Lattice sliced potatoes
13. **Green peas**
14. Green peas
15. **Spring salad bowl**
16. **Savory French dressing** (‡243)
17. **Dried apricot pie** (‡309)
18. Apricot whip
19. Strawberry gelatin
20. Fresh strawberries
21. Blended citrus juice

22. **Cream of spinach soup**
23. **Croutons**
24. **Baked codfish loaf with egg sauce—potato sticks**
25. Eggs goldenrod
26. Cottage cheese on lettuce
27. Baked potato
28. **Sliced new beets**
29. **Celery curls**
30. ———
31. **Mixed fruit cup**
32. Canned fruit cocktail
33. Soft custard
34. Fresh fruit cup
35. Pineapple juice
36. **Bran muffins** (‡68)

March 14

1. **Tomato juice**
2. Tomato juice
3. **Hominy or bran flakes**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Mushroom bouilion**
8. **Crisp crackers**
9. **Glazed ham loaf** (‡148)
10. Roast lamb
11. **Fluffy rice**
12. Fluffy rice
13. **Broccoli with lemon butter**
14. Frozen mashed squash
15. **Stuffed prune salad**
16. **Cream mayonnaise**
17. **Orange shortcake**
18. Cherry sponge
19. Cherry sponge
20. Orange sections
21. Grapefruit juice

22. **Grape juice with lemon sherbet**
23. ———
24. **Macaroni and cheese en casserole with sliced stuffed olives**
25. Macaroni and cheese (‡106)
26. Baked veal
27. Noodles
28. **Sliced carrots**
29. **Escarole and cress salad**
30. **Russian dressing**
31. **Marble cake with chocolate frosting**
32. Canned pears
33. Chocolate blanc mange
34. Unsweetened canned pears
35. Grape juice or consomme
36. **Bread**

March 15

1. **Orange slices**
2. Orange juice
3. **Wheat flakes or oatmeal**
4. **Soft cooked egg**
5. Bacon
6. **Cinnamon toast**

7. **Consomme with custard cubes**
8. **Saltines**
9. **Broiled chicken**
10. Roast chicken
11. **New potatoes in cream**
12. New potatoes
13. **Fresh asparagus**
14. Fresh asparagus
15. **Spiced peach and ripe olive salad**
16. **Fruit salad dressing**
17. **Meringue rings with raspberry sherbet** (‡277)
18. Vanilla ice cream
19. Lime ice
20. Half grapefruit
21. Blended citrus juice

22. **Cream of corn soup** (‡41)
23. **Crisp crackers**
24. **Sliced ham and cheese—deviled egg—tomato slice—potato chips**
25. Minced lamb en casserole with fluted mashed potato—green beans
26. Cold roast lamb—green beans—tomato salad
27. Stuffed baked potato
28. ———
29. ———
30. ———
31. **Fresh pineapple—angel food with orange icing**
32. Canned peaches—angel food (‡275)
33. Vanilla ice cream
34. Fresh pineapple
35. Apricot nectar
36. **Ice box rolls**

March 16

1. **Sliced bananas**
2. Prune juice with lemon wedge
3. **Farina or wheat and barley kernels**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **Tomato juice**
8. ———
9. **Yankee pot roast** (‡123)
10. Pot roast of beef
11. **Mashed potatoes**
12. Riced potatoes
13. **Cauliflower**
14. Carrot rings
15. **Carrot and raisin salad** (‡221)
16. **Cream mayonnaise**
17. **Devil's food cake** (‡263)
18. Sponge cake
19. Pineapple whip
20. Unsweetened Royal Anne cherries
21. Chicken broth or tomato juice

22. **Vegetable soup**
23. **Saltines**
24. **Creamed mushrooms on toast—candied sweet-potatoes**
25. Pan-broiled liver
26. Pan-broiled liver
27. Baked sweetpotato
28. **Green peas**
29. **Orange and grapefruit salad**
30. **French dressing**
31. **Cream cheese, guava jelly and toasted saltines**
32. Baked prune whip
33. Baked custard
34. Unsweetened canned boysenberries
35. Pineapple juice
36. **Bread**

March 17

1. **Grapefruit**
2. Blended citrus juice
3. **Crisp rice cereal or brown granular wheat cereal**
4. Poached egg (omit on Normal Diet)
5. Grilled ham
6. **French toast—syrup**

7. **Cream of celery soup**
8. **Crisp crackers**
9. **Baked breaded veal cutlet**
10. Broiled veal steak
11. **Parsley potatoes**
12. Parsley potatoes
13. **Harvard sliced beets**
14. Sliced beets
15. **Pear and grated cheese salad**
16. **French dressing**
17. **Pistachio ice cream**
18. Vanilla ice cream
19. Lemon ice
20. Unsweetened pear and plum compote
21. Orange juice

22. **Split pea soup** (‡46)
23. **Croutons**
24. **Scrambled eggs—bacon**
25. Scrambled eggs—bacon
26. Cold roast beef
27. Baked potato
28. **Fresh spinach**
29. **Tossed salad**
30. **Chiffonade dressing** (‡238)
31. **Pineapple, plum and apricot compote**
32. Pear and peeled apricot compote
33. Butterscotch pudding
34. Fresh fruit cup
35. Cherry juice
36. **Cornbread**

March 18

1. **Orange juice**
2. Orange juice
3. **Oatmeal or corn flakes**
4. **Soft cooked egg**
5. Link sausages
6. **Honey raisin buns**

7. **Julienne vegetable soup**
8. **Saltines**
9. **Creamed turkey in noodle ring or fish**
10. Hot sliced turkey or fish
11. ———
12. Riced potatoes
13. **Broccoli**
14. Wax beans
15. **Frozen fruit salad**
16. ———
17. **Chocolate pudding** (‡336)
18. Chocolate pudding
19. Grape sponge
20. Fresh strawberries
21. Tomato juice

22. **Potato and chive soup**
23. **Toasted crackers**
24. **Baked corn pudding—crisp bacon** (‡201)
25. Broiled lamb pattie—carrots
26. Broiled lamb pattie—carrots
27. Potato balls
28. ———
29. **Mixed green salad**
30. **Clear French dressing**
31. **Fresh or frozen strawberries—sugar cookies** (‡303)
32. Grapefruit sections with grenadine
33. Chocolate blanc mange
34. Half grapefruit
35. Apricot nectar
36. **Bread**

March 19

1. **Blended citrus juice**
2. Blended citrus juice
3. **Crisp oat cereal or farina**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **Cream of carrot soup**
8. **Crisp crackers**
9. **Pan fried cubed steak**
10. Broiled cubed steak
11. **French fried potatoes**
12. New potatoes
13. **Tomatoes and silver skin onions**
14. Asparagus tips
15. **Raw vegetable salad bowl** (‡223)
16. **Herb French dressing**
17. **Orange floating island** (‡339)
18. Orange floating island
19. Orange gelatin cubes
20. Orange slices
21. Limeade

22. **Turkey celery soup**
23. **Saltines**
24. **Chipped beef, noodle and cheese casserole**
25. Noodle cheese casserole
26. Baked veal chop
27. Baked noodles in broth (omit on Soft Diet)
28. **Green beans**
29. **Banana, red apple and grapefruit salad**
30. **French dressing**
31. **Peppermint stick ice cream**
32. Prune whip
33. Peppermint stick ice cream
34. Unsweetened canned plums
35. Pineapple juice
36. **Blueberry muffins** (‡67)

March 20

1. **Sliced banana**
2. Orange juice
3. **Rolled wheat or crisp corn cereal**
4. **Poached egg**
5. Link sausages
6. **Toast**

7. **Cream of asparagus soup** (‡35)
8. **Melba toast**
9. **Shrimp Creole on rice** (‡173)
10. Broiled salmon steak
11. ———
12. Paprika potatoes
13. **Green peas**
14. Green peas
15. **Celery and rose radishes**
16. ———
17. **Apple dumpling with nutmeg sauce** (‡328, 385)
18. Bread pudding with jelly
19. Raspberry gelatin
20. Unsweetened canned apricots
21. Grapefruit juice

22. **Cream of mushroom soup**
23. **Crisp crackers**
24. **Tuna salad in toasted roll—spiced crabapple on cress—potato chips**
25. Creamed tuna—spinach
26. Low fat tuna on lettuce—spinach
27. Baked potato
28. ———
29. **Tomato slices**
30. ———
31. **Cup cakes with strawberry fluff frosting**
32. Canned peeled apricots
33. Baked custard
34. Fruit plate—pineapple wedges and fresh strawberries
35. Mixed fruit juice
36. ———

March 21

1. **Orange halves**
2. Prune juice with lemon wedge
3. **Wheat flakes or oatmeal**
4. **Scrambled egg**
5. Bacon
6. **Raisin toast**

7. **Alphabet soup**
8. **Whole wheat crackers**
9. **Roast loin of pork**
10. Roast beef
11. **Browned potatoes**
12. Cubed potatoes
13. **Turnip greens or carrots**
14. Quartered carrots
15. **New cabbage, pineapple and marshmallow salad**
16. ———
17. **Cottage pudding with chocolate sauce** (‡334, 381)
18. Cottage pudding with chocolate sauce
19. Lime ice
20. Unsweetened fruit compote
21. Blended citrus juice

22. **Mulligatawny soup** (‡44)
23. **Saltines**
24. **Shepherds pie with fluted mashed potato top**
25. Minced lamb in casserole with mashed potato topping
26. Broiled lamb chop
27. Riced potatoes
28. **Sliced beets**
29. **Romaine and lettuce salad bowl**
30. **Vinegar-oil dressing**
31. **Peach half with frozen raspberries**
32. Applesauce
33. Cream pudding
34. Unsweetened applesauce
35. Orange juice
36. **Sweet cinnamon rolls** (‡86)

March 22

1. **Grapefruit**
2. Blended citrus juice
3. **Hominy or wheat and barley kernels**
4. **Poached egg**
5. Bacon
6. **English muffins—orange marmalade**

7. **Beef bouilion**
8. **Saltines**
9. **Oven fried chicken with cream gravy**
10. Roast chicken
11. **Mashed potatoes**
12. Riced potatoes
13. **Parsley wax beans**
14. Wax beans
15. **Hearts of lettuce salad**
16. **Chiffonade dressing** (‡238)
17. **Fresh strawberry sundae**
18. Vanilla ice cream
19. Cranberry sherbet (no cream)

‡ Arabic numerals indicate page on which recipe may be found in "Large Quantity Recipes," by Margaret E. Terrell, Philadelphia, J. B. Lippincott. $7.

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20. Fresh strawberries
21. Orange juice

22. **Chicken noodle soup**
23. **Toasted crackers**
24. **Welsh rarebit on Melba toast** (‡103)
25. Welsh rarebit on Melba toast
26. Cold roast beef
27. Baked potato
28. **Fresh asparagus**
29. **Carrot sticks and celery**
30. ———
31. **Fresh pineapple-cornflake macaroons**
32. Royal Anne cherries
33. Vanilla ice cream
34. Fresh pineapple
35. Tomato juice
36. **Bread**

March 23

1. **Orange juice**
2. Orange juice
3. **Corn flakes or rolled wheat**
4. **Soft cooked egg**
5. Grilled chicken livers
6. **Toast**

7. **Consomme**
8. **Crisp crackers**
9. **Roast leg of veal**
10. Roast leg of veal
11. **Scalloped potatoes**
12. Lattice sliced potatoes
13. **New beets and greens**
14. New beets and greens
15. **Mixed fruit salad with cooked fruit dressing**
16. ———
17. **Boston cream pie** (‡333)
18. Boston cream pie
19. Whipped cherry gelatin
20. Unsweetened canned fruit cocktail
21. Grapefruit juice

22. Tomato cheese soup (‡50)
23. **Croutons**
24. **Sauteed chipped beef and mushrooms on toast**
25. Minced beef on toast
26. Broiled chopped steak
27. Potato puffs
28. **Patty pan squash with lemon juice**
29. **Shredded cabbage, green pepper and pimento salad**
30. **Tarragon French dressing**
31. **Half grapefruit with grenadine**
32. Canned peaches
33. Chocolate rennet-custard
34. Unsweetened canned peaches
35. Fruitade
36. **French bread**

March 24

1. **Fresh strawberries**
2. Grapefruit juice
3. **Oatmeal or puffed wheat**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **Tomato bouillon**
8. **Whole wheat crackers**
9. **Brown beef and vegetable stew** (‡137)
10. Hot beef cubes
11. ———
12. New potatoes
13. **Oven-browned parsnips**
14. Spinach with lemon wedge
15. **Sliced head lettuce salad**
16. **Paprika French dressing**
17. **Cherry cobbler** (‡352)
18. Orange ice
19. Orange ice
20. Diced orange cup
21. Limeade

22. **Cream of celery soup**
23. **Saltines**
24. **Hot turkey sandwich—peach cup with cranberry sauce on cress**
25. Hot sliced turkey sandwich—asparagus
26. Hot sliced chicken—whole carrots
27. Riced potatoes
28. ———
29. **Asparagus salad**
30. **French dressing**
31. **Fruit gelatin**
32. Canned fruit gelatin
33. Raspberry gelatin with custard sauce
34. Unsweetened canned bing cherries
35. Peach nectar
36. ———

March 25

1. **Grapefruit**
2. Apricot nectar with lemon
3. **Shredded wheat or farina**
4. Poached egg (omit on Normal Diet)
5. Link sausages
6. **Griddle cakes—syrup**

7. **Cream of spinach soup**
8. **Melba toast**
9. **Country style liver or fish**
10. Pan-fried liver or fish
11. **Stuffed baked potato**
12. Baked potato
13. **Stewed tomatoes**
14. Green beans
15. **Chef's salad bowl**
16. **Chef's salad dressing**
17. **Lemon meringue pie** (‡319)
18. Lemon meringue pudding
19. Lemon snow pudding
20. Unsweetened pear and plum compote
21. Blended citrus juice

22. **Vegetable soup**
23. **Crisp crackers**
24. Ham and eggs on toast au gratin (‡147)
25. Creamed diced veal
26. Baked veal chop
27. Fluffy rice
28. **Green peas**
29. **Celery and radishes**
30. ———
31. **Baked cherry rhubarb**
32. Orange and banana cup
33. Baked custard
34. Orange and banana cup
35. Pineapple juice
36. **Hot orange biscuits**

March 26

1. **Orange slices**
2. Orange juice
3. **Brown granular wheat cereal or corn flakes**
4. **Soft cooked egg**
5. Bacon
6. **Coffee cake**

7. **Consomme**
8. **Saltines**
9. **Roast fresh ham with dressing**
10. Roast lamb
11. **Mashed potatoes**
12. Riced potatoes
13. **Sliced carrots**
14. Sliced carrots
15. **Waldorf salad** (‡215)
16. ———
17. **Chocolate chip ice cream**
18. Chocolate chip ice cream
19. Lime ice
20. Pink grapefruit sections
21. Grapefruit juice

22. **Chicken rice broth**
23. **Crisp crackers**
24. **Spaghetti with Italian meat sauce** (‡132)
25. Meat balls—asparagus
26. Meat balls—zucchini
27. Spaghetti with tomato puree
28. ———
29. **Raw vegetable salad bowl**
30. **Russian dressing**
31. **Fruit plate—pineapple wedges and fresh strawberries**
32. Canned pears
33. Floating island (‡339)
34. Pineapple wedges and whole strawberries
35. Mixed fruit juice
36. **Hard rolls**

March 27

1. **Grapefruit juice**
2. Grapefruit juice
3. **Puffed rice or oatmeal**
4. Scrambled egg (omit on Normal Diet)
5. Bacon
6. **French toast triangles—jelly**

7. **Cream of potato soup**
8. **Crisp crackers**
9. **Baked breaded haddock fillets**
10. Baked haddock fillets
11. **Potatoes au gratin**
12. Cubed potatoes
13. **Spiced beets**
14. Sliced beets
15. **Cole slaw** (‡221)
16. ———
17. **Fruit ambrosia—butter cookies** (‡301)
18. Grape sponge—rich cookies
19. Grape sponge
20. Fresh fruit cup
21. Blended citrus juice

22. **Clam chowder**
23. **Oyster crackers**
24. **Cheese souffle** (‡100)
25. Cheese souffle
26. Cottage cheese
27. Baked potato
28. **Spinach**
29. **Tomato salad**
30. **French dressing**
31. **Lemon layer cake**
32. Canned peeled apricots
33. Raspberry rennet-custard
34. Unsweetened canned apricots
35. Orange juice
36. **Cloverleaf rolls**

March 28

1. **Sliced banana**
2. Tomato juice
3. **Rolled wheat or crisp corn cereal**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Consomme**
8. **Saltines**
9. **Roast leg of lamb—currant jelly**
10. Roast leg of lamb (‡139)
11. **Mashed potatoes**
12. Riced potatoes
13. **Mashed rutabagas or squash**
14. Diced yellow squash
15. **Pineapple and stuffed date salad**
16. **Cream mayonnaise**
17. **Tapioca cream with meringue**
18. Tapioca cream with meringue
19. Raspberry ice
20. Fresh pineapple cup
21. Orange juice

22. **Cream of mushroom soup** (‡44)
23. **Melba toast**
24. **Baked corned beef hash**
25. Broiled veal pattie
26. Broiled veal pattie
27. New potatoes in jackets
28. **Julienne green beans**
29. **Grapefruit and avocado salad**
30. **French dressing**
31. **Date sandwich cake with whipped cream** (‡264)
32. Canned peaches
33. Baked custard
34. Unsweetened canned boysenberries
35. Apricot nectar
36. **Bread**

March 29

1. **Orange juice**
2. Orange juice
3. **Bran flakes or farina**
4. **Soft cooked egg**
5. Grilled Canadian bacon
6. **Corn muffins** (‡69)

7. **Vegetable soup**
8. **Crisp crackers**
9. **Braised beef roast**
10. Braised beef roast
11. **Franconia potatoes**
12. New potatoes
13. **Broccoli with Hollandaise sauce**
14. Julienne carrots
15. **Vegetable salad** (‡223)
16. **Savory dressing** (‡243)
17. **Caramel sundae**
18. Vanilla ice cream
19. Lemon ice
20. Grapefruit sections
21. Grapefruit juice

22. **Corn chowder** (‡41)
23. **Oyster crackers**
24. **Tomato aspic ring with cabbage and carrot slaw—cheese sandwiches**
25. Creamed eggs—peas
26. Cold sliced lamb—peas—tomato salad
27. Baked potato
28. ———
29. ———
30. ———
31. **Pineapple upside-down sponge cake with whipped cream**
32. Royal Anne cherries
33. Chocolate pudding
34. Unsweetened canned Royal Anne cherries
35. Mixed fruit juice
36. ———

March 30

1. **Grapefruit**
2. Grapefruit juice
3. **Hominy or wheat flakes**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **Beef noodle soup**
8. **Saltines**
9. **Spanish pork cutlet with rice** (‡144)
10. Roast veal loin
11. ———
12. Riced potatoes
13. **Green beans**
14. Green beans
15. **Sliced head lettuce salad**
16. **Russian dressing** (‡243)
17. **Apple pan dowdy** (‡348)
18. Vanilla blanc mange with cherry sauce
19. Cherry sponge
20. Unsweetened canned peaches
21. Blended citrus juice

22. **Cream of broccoli soup**
23. **Croutons**
24. **Meat-stuffed cabbage roll's** (‡129)
25. Broiled beef pattie
26. Broiled beef pattie
27. Cubed potatoes
28. **Sliced new beets**
29. **Orange and cherry salad**
30. **Paprika French dressing**
31. **Baked prune whip with chilled custard sauce**
32. Baked prune whip
33. Chilled soft custard
34. Unsweetened canned pear and plum compote
35. Pineapple juice
36. **Parker House rolls**

March 31

1. **Tomato juice**
2. Tomato juice
3. **Crisp rice cereal or brown granular wheat cereal**
4. **Poached egg**
5. Bacon
6. **Cinnamon muffins**

7. **Cream of mushroom soup**
8. **Melba toast**
9. **Chicken loaf** (‡158)
10. Hot sliced chicken
11. **Paprika new potatoes**
12. New potatoes
13. **Fresh asparagus**
14. Fresh asparagus
15. **Relishes—carrot sticks and ripe olives**
16. ———
17. **Fresh or frozen strawberries**
18. Bread pudding with jelly (‡335)
19. Raspberry gelatin
20. Fresh strawberries
21. Grapefruit juice

22. **Apricot nectar with lemon sherbet**
23. ———
24. **Canadian bacon—scalloped potatoes**
25. Pan-broiled liver—scalloped potatoes
26. Pan-broiled liver
27. Riced potatoes (omit on Soft Diet)
28. **Fresh spinach with lemon**
29. **Stuffed celery**
30. ———
31. **Banana cake with caramel frosting** (‡261)
32. Banana and orange cup
33. Vanilla ice cream
34. Orange slices
35. Chicken broth or apricot nectar
36. **Bread**

‡ Arabic numerals indicate page on which recipe may be found in "Large Quantity Recipes," by Margaret E. Terrell, Philadelphia, J. B. Lippincott. $7.

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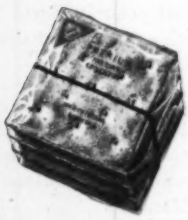

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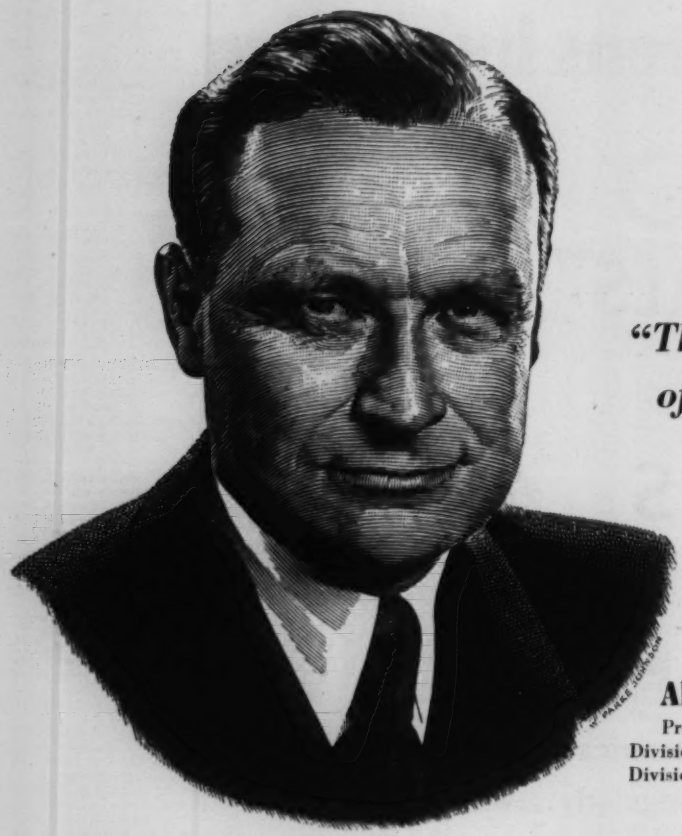

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ALDEN G. ROACH
President, Columbia-Geneva Steel Division and Consolidated Western Steel Division, United States Steel Corporation

"It is most gratifying to me that the employees of the Columbia-Geneva Steel Division and the Consolidated Western Steel Division of United States Steel Corporation have accorded meaning to their belief that the security of our nation rests upon our cooperative effort. The enthusiastic response of our employees made me doubly glad we conducted a person-to-person canvass for the Payroll Savings Plan for U. S. Defense Bonds."

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Employees *want* to provide for their future security.

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As a step toward *your* personal security, and the security of your associates, bring this page to the attention of your top executive. Tell him that—

- a person-to-person canvass of your plant can be conducted without pressure, prize awards or other stimulation. (In many plants, employee organizations have undertaken the actual distribution of Payroll Savings Application Blanks.)
- The Savings Bond Division, U. S. Treasury Department, Suite 700, Washington Building, Washington, D. C., will gladly help your company with suggestions, posters, envelope stuffers and other aids.

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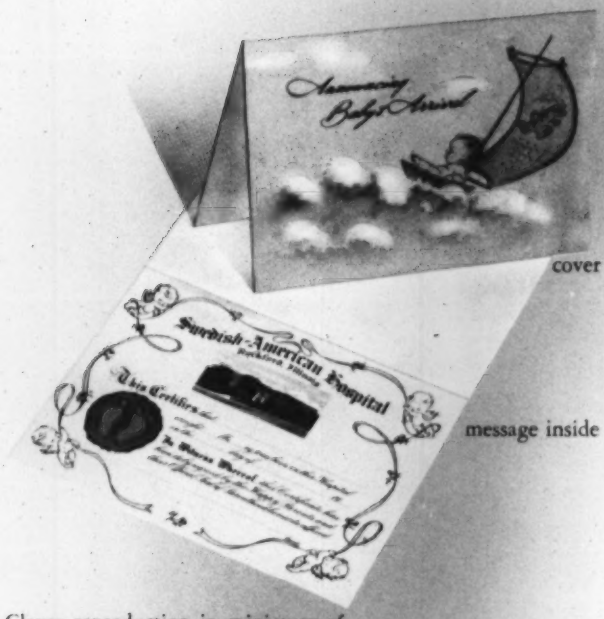

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HOSPITALS everywhere are cashing in on the profit possibilities of these newly designed Hollister Announcements. You need sell only 300 boxes of 12 (at $1.85 each) to make a profit of at least $217!

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Both Mother and Baby have identical bands, with identical numbers *pre-printed* inside. And once you seal them on the Mother's wrist and Baby's wrist in the delivery room, they can never be changed, they can never ever be used for another baby.

Nurses everywhere are acclaiming this the fastest, surest, yet easiest method of newborn identification. Fits right into delivery room procedure, no extra work or effort. Inspires confidence of both patient and doctor in your high standard of operation. And remember too, the Ident-A-Band system meets all the requirements for positive, unalterable, correlated Mother-Baby identification as recommended by the AHA.

Free yourself from mixup worries, see how easy it is to have trouble-free, complete protection at all times. Send the coupon below for details, samples and prices. (Ident-A-Bands are ideal for Pediatrics and General Patient use as well as correlated Mother-Baby identification.)

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Please send me by return mail a sample HOLLISTER IDENT-A-BAND with detailed information at no cost or obligation.

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· · ORGANIZATIONS · ·

HIF To Sponsor Four Research Projects

A $275,000 research program consisting of four major studies has been initiated by the Health Information Foundation, according to Admiral W. H. P. Blandy, USN (Ret.), the foundation's president. The purpose of the study is to determine the coverage and effectiveness of voluntary health insurance plans and indicate areas where extension of coverage and benefit provisions are required. Data for three of the studies will be compiled by the end of the year; while information for the fourth study will not be completed until 1955.

The first study is a national sampling of American households to discover the relationship between family costs of medical care and health status, the bearing which prepaid health insurance plans have on this relationship, and attitudes toward health needs and insurance. The second phase will investigate specific communities to seek data on the economic impact upon the family of illness not covered, effect of insurance plans on the use of health services and facilities and desire for additional coverage. The National Opinion Research Center, University of Chicago, under direction of Clyde W. Hart, will conduct the first two studies.

Analysis of the present types of plans in selected communities will be the topic of the third study with the purpose of determining how the plans may be extended to include certain people not now covered—such as farmers, retired persons, and the indigent and low-income families. The communities selected will be those in which health and welfare agencies, the medical profession, and hospitals, together with the commercial and nonprofit health insurance plans in the communities, and the local government are willing to combine forces in experimental programs. Although the program will be aimed at determining the best method of providing for the health needs of all groups in each community, special attention will be paid to providing means of adequate hospital and medical care for the low-income and indigent groups.

The fourth project will seek data on family debts and their relationship to illnesses and medical costs. The last two studies are being undertaken by HIF's own research staff, headed by Dr. Odin W. Anderson, and in consultation with Mr. Hart.

During the entire study the foundation will keep in close touch with the progress of the Columbia University project on methods of payment of medical care in the United States, the research of the Commission on Chronic Illness and the results of the study of the Commission on the Financing of Hospital Care.

It is hoped that the results of these studies can lead to the development of similar programs by individual communities throughout the nation. These studies are the latest in a group of 14 research projects on health services and facilities, sponsored by the foundation since its inception in 1950. Supported by the drug, pharmaceutical, chemical and allied industries, the foundation collects and distributes factual information on health care, progress and services in the United States.

California Association Elects Officers

Thomas P. Langdon, administrator of Hahnemann Hospital, was chosen as president-elect of the California Hospital Association at the recent annual meeting in Santa Barbara.

George J. Badenhausen, administrator of the Harriman Jones Clinic and Hospital, Long Beach, was installed as president. Other officers are: Executive vice-president, E. E. Salisbury, San Francisco and treasurer, Fred W. Moore, administrator, Rideout Memorial Hospital, Marysville. Elected to the positions of first and second vice-presidents, respectively, are: J. E. Smits, administrator, Children's Hospital, Los Angeles, and Alfred E. Maffly, administrator, Herrick Memorial Hospital, Berkeley.

Delegates to the American Hospital Association are Orville N. Booth, administrator, St. Francis Memorial Hospital, San Francisco,

PHOTOGRAPHED AT the semi-annual meeting of the American Surgical Trade Association in New York City on December 16 were (left to right): Dr. Madison B. Brown, executive vice president of Roosevelt Hospital, New York City; Robert C. Blackwood and Robert E. Anderson Jr., treasurer and president, respectively, of the American Surgical Trade Association, and George Bugbee, executive director of the American Hospital Association.

and D. L. Braskamp, administrator, Alhambra Community Hospital.

Richard Highsmith, director of Children's Hospital, Oakland, and George B. Nelson, superintendent, Glendale Sanitarium and Hospital, were selected as alternates to the American Hospital Association.

Awards, Panel Highlight Hospital Auxiliary Meeting

Presentation of certificates of merit and discussion of the relationship of the auxiliary to the hospital administrator were the chief activities of the Third Annual Illinois Conference of Women's Hospital Auxiliaries in Springfield, November 20.

James R. Gersonde, executive director of the Illinois Hospital Association, presented certificates of merit for fund raising, volunteer service, tray favors and scrapbooks to representatives of 12 hospital auxiliaries. Children's Memorial Hospital, Chicago, received a special citation for its auxiliary program in fund raising and volunteer service.

In the panel discussion Cecil G. Frantz, Monmouth Hospital, explained the hospital administrator's relationship to the auxiliary; Mrs. William F. Bennett, Clay County Hospital, Flora, presented the board of trustee's relationship. The Rev. John Weisnar, director of hospitals, Diocese of Joliet, told the community relation needs.

Other speakers were: Albert V. Whitehall, director of the American Hospital Association's Washington Service Bureau, whose subject was "The Hospital in Your Community;" and Mrs. Samuel O. Winograd, member of the National Committee on Women's Hospital Auxiliaries and of the Women's Board, Michael Reese Hospital, Chicago.

Public Welfare Expert Joins APWA Staff

Maurice O. Hunt, administrator of the Indiana State Department of Public Welfare, has been named assistant director of the American Public Welfare Association.

After graduate training in social work he entered the field of public welfare. His experience includes the fields of public assistance, governmental research, institutional programs, child welfare, Council of Social Agencies, as well as work with UNRRA, where he held posts with the Albania and Greek missions.

WILLIAM E. SMITH, new executive director of the Hospital Industries' Association is being wished good luck by retiring president, Charles E. Pain. New officers pictured (from left) are: J. J. Egan, secretary-treasurer; Roger C. Wilde, president; E. Jack Barns, trustee; George J. Hooper, member of steering committee; Howard F. Baer, vice-president; William E. Smith, executive director; Thomas G. Murdough, trustee; Charles E. Pain, retiring president; Victor A. Noel, director and Harland Prater, director.

West Virginia Secretary

The West Virginia Hospital Association has instituted the office of executive secretary. William R. Huff has been named for the position with his office in the Morrison Building, Charleston.

Improvement of Exhibits Topic of HIA Meeting

Ways and means of improving the exhibits of the various national, regional and state hospital groups that hold conventions with technical exhibits was the subject of discussion at the meetings of the executive committee of the Hospital Industries' Association and the officers of the hospital associations at the Drake Hotel in Chicago, October 23. The 1952 exhibits were reviewed and the hospital representatives were given the counsel of the Hospital Industries' Association as to what specific part of the shows could be strengthened.

In 1953 the association plans to improve the brochures which it publishes for certain hospital groups. During the coming year the association will send its executive director to an increased number of conventions in order to render additional service to member exhibitors.

Installation of new officers preceded the meetings with the hospital officials. (See picture.)

Fire Safety, Disaster Plans To Be Discussed at Institute

An institute on emergency planning for all Mississippi Hospitals will be held in Jackson, February 10-11. This meeting is being cosponsored by the Mississippi Commission on Hospital Care and the Mississippi State Hospital Association. The institute will be divided into three sections: Fire safety organization, disaster planning, and safeguarding against operating room hazards.

Capt. C. H. Whittaker, fire training officer for the Mississippi Department of Education, will discuss fire hazards and put on a demonstration of the use of fire-fighting equipment. "What To Do When Fire Strikes" will be the topic discussed by Mrs. M. M. Barfield, director of nursing at the Baptist Hospital, Jackson, and T. F. McDonald, chief of the Jackson Fire Department. The new American Hospital Association film on

Provides Protection

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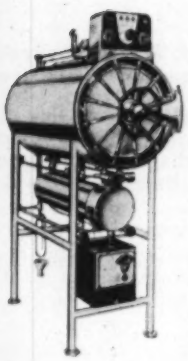

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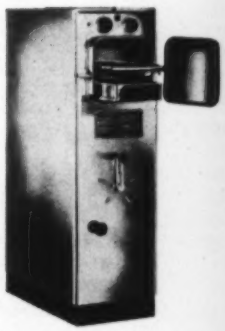

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And you can use detergents and cleansers freely (or simply soap and water) to keep a Monel sterilizing unit as bright and shiny as new.

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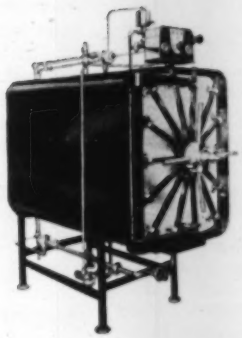

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"Fire—and your Hospital" will be shown.

Dr. Alexis Anikeef of Mississippi State College will orient the group on the "Psychology of Fear," while a panel of five hospital trustees will discuss their responsibility in emergency planning. A Jackson insurance safety engineer is scheduled to outline salient points on "Fire Drills."

Moody Moore, director of the Division of Hospitals of the State of Arkansas will present the disaster plan of Arkansas utilized recently in handling tornado victims. Dr. George J. Thomas from the St. Francis Hospital, Pittsburgh, will discuss and demonstrate, with actual gaseous explosions, the hazards which are sometime present in operating rooms.

The meeting is open to hospital personnel, insurance company representatives, and officials working with fire and disaster control.

F. R. Franzoni Elected APA President

Officers of the American Pharmaceutical Association were elected by a mail ballot participated in by all members in good standing. The new officers will be installed at the annual convention in Salt Lake City the week of August 16.

The new officers are: President-elect, F. Royce Franzoni, practicing pharmacist and member of the Board of Pharmacy of the District of Columbia; first vice-president-elect, John A. MacCartney, director of trade relations, Parke, Davis and Company; second vice-president-elect, Joseph B. Sprowls, dean, College of Pharmacy of Temple University, Philadelphia.

Members-elect of the Council for a term of three years are: Don E. Francke, chief pharmacist, University of Michigan Hospital; Roy L. Sanford, Enid, Okla, practicing pharmacist, and Robert L. Swain of New York City, editor, *Drug Topics and Drug Trade News.*

Allen Beck Elected President of ASHP

Allen V. R. Beck has been elected president of the American Society of Hospital Pharmacists by a mail ballot. Other officers are: Vice-president, Adela Schneider, Houston; and treasurer, Anna D. Thiel, Miami, Fla.

The new officers will be installed at the annual convention to be held in Salt Lake City during the week of August 16.

APHA to Prepare Manual On Health Administration

A $12,000 grant has been made to the American Public Health Association by the W. K. Kellogg Foundation to enable the Association to prepare and publish a manual of local health administration.

Although the manual is intended primarily as a guide to the best prevailing standards and methods, it is hoped that it can be prepared in such a way as also to prove helpful in identifying and meeting the major public health problems of the immediate future. The new manual is not to be regarded as a substitute for similar publications issued by state health departments and adapted to the particular needs of the separate states, but rather as a stimulus and guide for the preparation of state manuals.

This project of the American Public Health Association is the eleventh one in the past 18 years that has been aided by grants from the Kellogg Foundation. Expenditures for these projects total approximately $320,000. Half of the projects have been concerned primarily with the improvement of local public health services.

Dr. Press Joins Polio Foundation Staff

Dr. H. A. Press, for some years director of the program analysis staff of the Department of Medicine and Surgery of the Veterans Administration and for the past year assistant to the chairman of the President's Commission on the Health Needs of the Nation, has joined the National Foundation for Infantile Paralysis. His office is in San Francisco.

David M. Kinzer Named IHA Assistant Director

To step up its program of service to members, the Illinois Hospital Association has appointed an assistant director, David M. Kinzer, of Chicago. Before he assumed his position December 1, Mr. Kinzer was associated with the Commission on the Financing of Hospital Care. He has also been a member of the headquarters staffs of the American Hospital Association and the American Dental Association.

A native of Pittsburgh, Mr. Kinzer is a graduate of Allegheny College, Meadville, Pa. He did graduate work in journalism at Northwestern University, Evanston, Ill., and in sociology at the University of Stockholm, Sweden.

J. B. H. Martin to Develop Program for Administrators

Through a $22,500 grant from the W. K. Kellogg Foundation to the Indiana Hospital Association, it will be possible to develop an educational program for governing boards and provide consultative assistance to governing boards and administrators. J. B. H. Martin, member of the Hospital Licensing Council, who recently retired as administrator of the Indiana University Medical Center, has been selected to carry out this work over a three-year period.

Mr. Martin's office will be at the Indiana State Board of Health. He will work closely with the Division of Hospital and Institutional Services, the Indiana State Board of Health, and the Hospital Licensing Council.

N. Y. Trustees Approve New Dues Plan

At the mid-year meeting of the Board of Trustees of the Hospital Association of New York State, held December 6 in New York City, a revision of the dues structure was approved by the board, as recommended by the executive committee.

There are now five institutional membership classifications rather than four. Based on total beds and bassinets, the new rates will be as follows: $25, Class 1 (49 or less beds and bassinets); $35, Class 2 (50-99 beds and bassinets); $52.50 Class 3 (100-199 beds and bassinets); $70, Class 4 (200-299 beds and bassinets); and $87.50, Class 5 (300 and over beds and bassinets).

Biggest Building Permit

The biggest individual building permit in Montreal's history—$15,000,000—has been issued by the building inspection division for construction of the new Montreal General Hospital.

The hospital now is being built in the Cote des Neiges road—Pine and Cedar avenues area.

Agenda Set for Mid-Year Conference

A panel on problems facing the hospital field and a workshop on establishing objectives and programs for state hospital associations will be the two main items on the agenda for the first day of the annual Mid-Year Conference of Presidents and Secretaries of State Hospital Associations, to be held at the Drake Hotel, Chicago February 6-7.

Dr. Edwin L. Crosby, president of the American Hospital Association, will open the Friday morning panel with a general statement of problems facing the hospital field. National Blue Cross programs will be the topic of the second panel speaker, James E. Stuart, chairman of the Blue Cross Commission. Maurice J. Norby, deputy executive director of the Association, will discuss the recent third-party payment conference, held at Highland Park, Ill. Dr. Charles U. Letourneau, secretary of the Council on Professional Practice, will discuss the American Hospital Association's participation in the accreditation program.

Mrs. Philander S. Bradford, chairman of the Committee on Women's Hospital Auxiliaries, will report on auxiliary progress. Oliver G. Pratt, executive director of the Rhode Island Hospital, Providence, will speak on management development, and Leo E. Brown will speak on medical-hospital relations. Mr. Brown is public relations director for the American Medical Association.

The workshop on establishing objectives and programs for the associations will be divided into four groups with the following presiding officers: Dr. Anthony J. J. Rourke, director of the Hospital Council of Greater New York; Dr. Crosby; Mr. Pratt; and George Bugbee, the Association's executive director.

Late Friday afternoon the post-election health legislation outlook will be discussed by William S. McNary, executive vice-president, Michigan Hospital Service, Detroit; Albert V. Whitehall, director of the Association's Washington Service Bureau, and Marion Foster, also of the Washington Service Bureau.

Friday's meeting will close with a president's reception from 5-7 P.M.

Saturday's agenda will begin with a panel on planning state and regional meetings with Malcom S. Knowles, administrative coordinator, Adult Education Association as moderator.

Mr. Bugbee will open the floor for discussion on "What Can We Do To Help Small Hospitals?" Special attention will be paid to the most pressing needs of small hospitals and the ways state associations may meet these problems.

Personnel Administration Committee Makes Plans

While major emphasis of the January 8-9 meetings of the Association's Committee on Personnel Administration was given to discussing the purposes and new functions voted it by the House of Delegates in September, a number of specific work projects were considered and authority for getting them under way approved. Several of these projects had already been started and their progress was reviewed by the committee. Among these and new activities discussed by the committee are:

1. The draft of a document on "Management in Hospitals and Development of Leadership Skills." (This document is now being circulated by mail to members of the Committees on Personnel Administration, Methods Improvement, and Organization, and to the Council on Administrative Practice for final recommendations and suggestions before being referred to the Coordinating Committee and Board of Trustees.)

2. A preliminary draft of a statement on "The Functions of the Committee on Personnel Administration."

3. Preparation of a glossary to clarify terminology concerning personnel administration.

4. An outline for a manual on "Centralization of Personnel Functions."

5. Preparation and completion of the next kits in its series of "how-to-do-it aids" primarily for the use by small hospitals without personnel department.

(a) An outline for a kit on methods for controlling costs of sick leave.

(b) Assignment of responsibility for the preparation of a detailed outline for a kit on employee house organs.

(c) Final review of the outline and initial draft of a kit on employment interviewing to be the next one distributed as a membership service.

(d) Assignment of responsibility for the preparation of an outline for a kit on hospital employees' handbook.

6. A five-day Institute on Personnel Administration to be conducted in Chicago in the fall of 1953.

As these various projects are completed and approved by the committee, they will be referred to the Council on Administrative Practice for review and recommendation to the Coordinating Committee and the Board of Trustees.

Hospital Housekeeping Course To Be Held April 6-May 29

The fifth annual short course in hospital housekeeping, sponsored by the American Hospital Association and Michigan State College, will be held on the campus at East Lansing from April 6 to May 29.

This eight week session is designed to give basic training in hospital housekeeping. Subjects include bacteriology, housekeeping procedures, buying and maintaining supplies and equipment, general cleaning and fire safety. The course also features classes in personnel management and employee training to train supervisors.

Each year Pacific Mills makes 10 scholarships available to this course. Administrators will select one applicant from their staff to participate in the scholarship competition. The applicant need only submit a statement of "Why I Am Interested in Hospital Housekeeping as a Career," and attach it to an entry form to become eligible.

Administrators of small hospitals may wish to employ someone new to assume housekeeping and dietary responsibilities and enroll the employee in the course this spring. Administrators of large hospitals may send a member of their staff with idea of setting up a training program upon return.

Fate of Health Bills Uncertain

It is still purely conjectural whether Congress will enact any major health legislation this year. Although many dozens of bills on hospital and medical care were introduced in the first two weeks of the new Congress, their fate will depend mainly on how they fit in with President Eisenhower's overall policies.

He has made it clear that he doubts the wisdom of Federal grants to medical and nursing schools—that he holds confidence in voluntary prepayment plans as a sound vehicle for health insurance—that he is unalterably opposed to compulsory health insurance. Beyond that, President Eisenhower so far has manifested no desire for the institution of any new and untried plans. It is becoming apparent that he wishes to leave the formulation of national health policies up to the Federal Security Agency and its new chief, Mrs. Oveta Culp Hobby.

One of the first things that will have to be done is to change the name of the Federal Security Agency which, after a half-decade under Oscar R. Ewing, has become synonymous in many minds with socialized medicine. In this regard, many Washington experts believe that one of President Eisenhower's first official acts will be to convert the agency into a Department of Health, Education and Security. This can be done by executive action, no Congressional legislation being required.

Committee Organization

The latter part of January witnessed organization of the two Congressional committees which handle all general health legislation, excepting only that which concerns veterans and the military. New chairman of Senate Labor and Public Welfare Committee is Senator H. Alexander Smith, (R., N.J.). Another New Jersey Republican, Rep. Charles A. Wolverton, will head the House Interstate and Foreign Commerce Committee.

Appointed to the Senate group were Senators Taft (Ohio), Aiken (Vt.), Ives (N.Y.), Purtell (Conn.), Goldwater (Ariz.) and Barrett (Wyo.), all Republicans. Democratic members are Murray (Mont.), Hill (Ala.), Neely (W. Va.), Douglas (Ill.), Lehman (N.Y.) and Kennedy (Mass.).

Serving with Representative Wolverton on the House Interstate and Foreign Commerce Committee are the following: Republicans—Hinshaw (Calif.), O'Hara (Minn.), Hale (Maine), Dolliver (Iowa), Heselton (Mass.), Bennett (Mich.), Hoffman (Ill.), Beamer (Ind.), Springer (Ill.), Bush (Pa.), Schenck (Ohio), Carrigg (Pa.) Warburton (Del.), Derounian (N. Y.), Pelly (Wash.), Younger (Calif.); Democrats—Crosser (Ohio), Priest (Tenn.), Harris (Ark.), Rogers (Fla.), Klein (N.Y.), Stanley (Va.), Granahan (Pa.), Carlyle (N.C.), Williams (Miss.), Mack (Ill.), Thornberry (Texas), Heller (N.Y.), Roberts (Ala.), Moulder (Mo.).

The one physician who is a new member of Congress, Rep. Will Neal (R., W.Va.), was assigned to the Public Works Committee. Another freshman member who is a dentist, Rep. George S. Long (D., La.) was named to the Committee on Veterans Affairs.

Doctor Draft Extension "Almost a Certainty"

Hospitals will be vitally interested in what Congress does about the doctor-draft act, which is due to expire June 30 but whose extension for another year is almost a certainty. Public hearings on this question are expected to be conducted by the House and Senate Committees on Armed Services early this spring, at which time all of the law's ramifications will be discussed. These include the effects on residency training; protection of civilian health requirements; geographical distribution problems, and others. Members of Congress are receiving large quantities of correspondence on the doctor draft. Most letters come from World War II medical veterans who request that any new legislation be worded so that non-veterans shall be required to serve in uniform before veterans have to come back in for a second tour of duty.

Congress in all probability will withhold final action on the doctor draft until the Supreme Court has had its say on this controversial matter. On January 13, the Supreme Court heard oral arguments in the case of Dr. Stanley Orloff, a New York psychiatrist who has contested the draft ever since his induction as a private in July, 1951.

Counsel for the federal government contended that Dr. Orloff, though an enlisted man in the Army, is being utilized as a physician at Madigan Hospital, Tacoma, Wash. His own lawyers disputed this claim, arguing that merely the fact that he is being denied a commission proves that Dr. Orloff is not being treated as a medical officer.

The government said Dr. Orloff's reluctance to reply to questions dealing with loyalty and associations precluded his being commissioned as an officer. But that did not mean his services as a physician necessarily should be declined, said the federal lawyers.

"To refuse his services would have violated at least the spirit of the doctors' draft law," said the government's brief, "for if petitioner (Orloff) were discharged, some other doctor would have to be drafted in his place.

"The only fair and practical alternative was to do what the Army has done, that is, to use his professional services without granting him a commission."

General Wilson to Germany

Brig. Gen. William L. Wilson, the Army doctor who was lent to the Federal Civil Defense Administration for six months, will leave FCDA this month—nearly two years after becoming its assistant director in charge of health and welfare services.

His next military assignment will be in Germany, as surgeon for the Seventh Army.

UMW Fund Pays for 500,000th Patient

Washington headquarters of the United Mine Workers of America Welfare and Retirement Fund disclosed that on January 9 the 500,000th patient was admitted to hospitalization under the fund's medical care program. The University of Pennsylvania Hospital was the institution figuring in this commemorative event, whose central character was Elmer Hassenflug, of Portage, Pa., who has been a miner for more than 40 years.

Meanwhile Dr. Warren F. Draper, executive medical officer of the Welfare and Retirement Fund, hailed the record to date of purchasing $97.10 in medical and hospital benefits for every $100 collected. (Financing of the fund is through royalty payments of 40 cents a ton on all bituminous coal produced for use or sale).

"This extraordinarily high percentage of funds channeled directly into a broad medical care program illustrates what can be done by a tightly-knit organization unhampered by red tape," said Dr. Draper.

"It shows that administrative costs can be minimized if you know the needs of the people you serve and have experienced personnel meet those needs. We think we have evolved a fair answer to socialized medicine. Miners, through their own toil, are producing better treatment for themselves and their families. We intend to make it even better as new techniques and facilities are developed or become available.

"All this entails a realistic willingness to collaborate with organized medicine as well as various federal and state agencies charged with improving the health and welfare of the American people. If in serving and enhancing the lot of over a million and a half beneficiaries, we can open new vistas for others, then we are indeed grateful for the opportunity afforded us in the welfare fund."

Voluntary insurance plans: Dr. Draper's remarks were occasioned by a statistical report published in the *Social Security Bulletin* for December, which included comparative figures on benefits paid by various kinds of voluntary insurance plans. With its ratio of 97.1 per cent, the mine workers' program was second only to student health services, which are subsidized and generally run at a deficit.

Blue Cross plans were found to expend 89.8 per cent of their earned income on hospitalization benefits. The Blue Shield rate of payment was 84.2 per cent. For commercial plans, the rate was 88.7 per cent on group insurance but only 52.3 on individual insurance.

Dr. Ross Appointed To VA Advisory Group

The appointment of Dr. Robert A. Ross, Durham, N. C., to the Veterans Administration's special medical advisory group was recently announced by Vice Admiral Joel T. Boone, chief medical director of the Veterans Administration.

Dr. Ross, professor and head of the department of obstetrics and gynecology at the University of North Carolina, replaces Dr. Robert A. Kimbrough Jr., Philadelphia, who resigned due to the pressure of other duties. Prior to his recent appointment, he was for 20 years on the staffs of Duke University Hospital and the university's medical school, as specialist in obstetrics and gynecology.

Professional societies of which Dr. Ross is a member include the American Medical Association, American College of Surgeons, American Association of Obstetricians, Gynecologists and Abdominal Surgeons, and various Southern medical organizations.

NPA Announces Construction Relaxations

Removal of the ban on the construction of recreational, amusement, and entertainment projects plus relaxations of other construction regulations, effective January 1, highlighted the activities of the Facilities and Construction Bureau of the National Production Authority in 1952.

These actions, originally scheduled for May 1, 1953, represent the most significant easing of construction controls by the National Production Authority since the institution of the original construction order, M-4, on October 26, 1950. The NPA was forced to postpone relaxations on the use of aluminum until May 1 due to lost aluminum production from power shortages in the Pacific Northwest and Tennessee Valley.

A resume of construction actions taken during 1952 indicates that beginning with the second quarter, the relaxation of controls under the Controlled Materials Program was reflected in more liberal allotments of materials and increased self-authorization privileges. On June 18, the National Production Authority increased self-certification of aluminum and copper for such uses as schools, hospitals, public buildings, small dwelling units, industrial and consumer products and commercial construction in order that small users could obtain their materials without filing applications. On July 9, the NPA granted permission to commence construction, where an applicant had enough carbon steel on hand to complete his building project. It applied to all types of construction except recreational, entertainment and amusement.

On October 3, R. A. McDonald, administrator of the National Production Authority, announced relaxation of construction regulations including the lifting of the ban on recreational construction to be effective May 1, 1953. On December 10, the administrator advanced the effective date of most of these relaxations to January 1, 1953.

Magnuson Commission Becomes Temporary Private Committee

Dr. Paul B. Magnuson, of Washington and Chicago, who was chairman of the President's Commission on Health Needs of the Nation, has disclosed that the 15-member group—now officially dissolved—has resolved itself into a private committee for the purpose of effecting countrywide distribution of its comprehensive report.

"We would like to see a copy of this report in the hands of practically every American," said Dr. Magnuson. "Our sole purpose is to educate the American public as to our findings. If, in the months to come, a group of citizens decides to form an organization to further

the aims of our report, that is all well and good.

"But we feel that our function as former commissioners is to do everything in our power to bring the basic information contained in our studies to the attention of the American people. Then it is up to them to act upon that information."

He emphasized that the group's mission will be temporary and that it does not plan to lobby in Congress for implementation of the recommendations which were forwarded in December to former President Truman.

Dr. Magnuson revealed that several members of the commission, possibly including himself, will participate in a national forum on the report which will be conducted by the National Health Council at its 33rd annual meeting in New York City March 18-20.

No Federal Wage Controls For Nonprofit Hospitals

All nonprofit hospitals under Section 101 of the Internal Revenue Code are now exempt from wage controls under action by the Wage Stabilization Board on November 20.

Exemption was limited formerly to hospitals classified under Section 101(6). Several hospitals classified under Section 101(8) found they could not be exempted.

Proprietary hospitals are still subject to wage controls but are exempt from price controls.

These federal controls do not apply to institutions operated by units of state or local government.

Federal Hospital Executives

Dr. Edwin L. Crosby, president of American Hospital Association and executive director of the Joint Commission on Accreditation of Hospitals, addressed the semi-annual luncheon of Federal Hospital Executives in Washington January 16. The theme of his speech was the need for research in various fields of hospital endeavors—design and construction, management and administration, professional staffing and community relations.

Fred A. McNamara, chief of Hospital Branch of the U.S. Bureau of the Budget, presided at the luncheon, which was attended by 97 high ranking government officials whose responsibilities encompass different phases of hospital operation.

Veterans Hospitalization

There is scarcely any doubt that the Veterans Administration's huge medical care and hospital activities will undergo tugging and hauling in 1953. Already several members of Congress have introduced bills designed to authorize construction of 16,000 more beds.

At least one of the veterans' organizations will campaign for this 16,000-bed expansion, which President Truman ordered postponed indefinitely several years ago for reasons of economy. Also, there will be spirited discussion on Capitol Hill of reorganization recommendations that were made by the Chicago management firm of Booz, Allen & Hamilton, which made an 18-month survey of the Veterans Administration and its operations.

Officials estimated that, at the close of 1952, veterans were being added to federal beneficiary rolls at the rate of about one million a year. At the end of November 1952 (latest month for which figures are available), the hospital census was 103,059 patients. All but 5,945 were in veterans hospitals.

Epidemic Intelligence Service Assists in Disease Control

The Epidemic Intelligence Service, a mobile corps of 32 epidemiologists of the Public Health Service of the Federal Security Agency, assisted state and local health departments in investigating and controlling more than 200 epidemics and three flood disasters during 1952, Surgeon General Leonard A. Scheele announced recently. The total was ten times greater than the average number of epidemic and disaster aid calls answered in recent previous years. Dr. Scheele explained that the increase was due to the fact that 1952 was the first full year of operation of the Epidemic Intelligence Service.

The service is a part of the Communicable Disease Center's epidemiology branch, headed by Dr. Alexander D. Langmuir of Atlanta. When not quelling epidemics, the 32 medical officers are assigned to state or local health departments, schools of medicine or public health, or other research laboratories strategically located in 16 states from coast to coast. At those posts they carry on continuing epidemiological investigations.

Dr. Scheele said that the more than 200 outbreaks studied in 1952 included 36 categories of diseases. There were 18 epidemics of infectious hepatitis, eight each of poliomyelitis and encephalitis, and one or more outbreaks of anthrax, brucellosis, German measles, infectious mononucleosis, influenza, malaria, psittacosis, rabies, suspected smallpox, typhoid fever, and others.

On two occasions the service sent epidemic consultants on overseas missions. An epidemiologist was lent to the World Health Organization for seven weeks in April and May to study and make recommendations for controlling a widespread outbreak of epidemic meningitis in Khartoum, Anglo-Egyptian Sudan, Africa. Another specialist was dispatched to Greenland in December to observe an epidemic of polio in Godthaab, the capital.

On three occasions the service sent professional specialists, equipment, and supplies to combat flood disasters. From April until June, the service furnished emergency assistance to the states of Iowa and Nebraska in controlling the health hazards created by the Missouri River flood. In May and June similar aid was given to Utah when flood waters inundated some 25,000 acres in five counties in Salt Lake Valley. Flash floods in two areas of Texas required the assignment there of Public Health Service personnel.

California requested the Communicable Disease Center's assistance in meeting the outbreaks of encephalitis and malaria. Tennessee health authorities called upon the center for assistance in epidemic jaundice; while Colorado sought the center's services in studying an outbreak of typhoid fever.

Hill-Burton Progress

At the close of the calendar year 1952, a total of 1,980 hospital and health center construction projects had been approved under the Hill-Burton hospital survey and construction program. Data in the Division of Hospital Facilities, Public Health Service, showed that 1,106 of the projects were completed and in operation as of the end of December; 713 were under construction and 161 were in preliminary stages.

The program has provided 96,428 hospital beds and more than 300 health centers, representing a total cost of approximately 1.6 billion dollars. The federal share will be about one-third.

FCDA Funds to Purchase Medical, Technical Items

Allocation of the remaining $3,000,000 in its $20,000,000 stockpiling program for 1952 was announced recently by the Federal Civil Defense Administration. Two million dollars will be spent for medical items and $1,000,000 for technical items.

The $2,000,000 to be spent for medical items will procure 600,000 bottles of dextrose and sodium chloride injection, 600,000 bottles of dextrose injection for intravenous fluid therapy of the seriously injured who can not take liquids by mouth, and 600,000 intravenous injection sets; 200,000 leg splints; and 398 portable field-operating lamps. This share of the allocation will also pay for transportation of 41,754 medical field kit cases and 200,418 medical field kit litter-carrying straps, which are being obtained without cost from the surgeon general's office of the Army.

The $1,000,000 for technical items will procure 45 mobile water chlorinator units, 81 five-kilowatt portable engine-driven generators, 81 forty-kilowatt portable engine-driven generators and almost 3,000,000 square yards of plastic window closures.

The FCDA stockpile, which is part of the federal emergency reserve, now amounts to $84,400,000 in medical and engineering items on hand or on order, plus an additional $2,600,000 earmarked for blood plasma.

Veterans Administration Assigns Dental Supervisors

The assignment of a dental supervisor to each of the Veterans Administration's six area medical offices was announced recently by Vice Admiral Joel T. Boone, chief medical director.

The dentists and the area medical offices to which each has been assigned are: Dr. M. Dee Medlin, Veterans Administration Center, Dayton to Boston; Dr. Harry R. Voekler, Veterans Administration central office, Washington, D.C. to Washington, D.C.; Dr. Stanton N. Bordner, Veterans Administration central office, Washington, D.C. to Atlanta; Dr. Edward Neenan, Veterans Administration Hospital, Bronx to St. Louis; Dr. Willis E. Krueger, Veterans Administration central office, Washington, D.C. to St. Paul; and Dr. Walter Lee, Veterans Administration Hospital, Denver to San Francisco.

· · NURSING · ·

Oregon Group Plans Institutes for Small Hospitals

Nursing institutes traditionally have been held in towns or cities where it was convenient for groups to come together to share a learning experience. It is obvious that only a limited number could attend from any one institution. Glen Howell, president of the Oregon Association of Hospitals, recognized the problem and determined to bring the institute to the hospital—especially to the small hospital that has limited funds to spend on sending its personnel far from home.

To put this idea into action, Mr. Howell invited representatives of the National League for Nursing, the Oregon State League for Nursing, the American Hospital Association and the Oregon State Department of Health to meet with him and Mrs. Olive White, director of nurses at Hood River Hospital, to plan a program that would meet the needs of the smaller hospitals.

This pilot institute was held at the Hood River Hospital in October. At this meeting plans were made for a series of one-day nursing service institutes to be held in Oregon during 1953. These institutes will be sponsored by the Oregon Association of Hospitals, the Oregon League for Nursing and the Oregon State Department of Health. The program will be focused on the problems of the smaller hospitals. Emphasis will be placed on the use of management skills as an aid to the better utilization of nursing personnel. A "traveling unit" will visit key points within the state.

It is hoped that in other states, the organizations responsible for improving nursing services within hospitals will cooperatively plan and sponsor programs similar to those planned in Oregon.

March of Dimes Grant Aids Nurse Recruitment Program

A March of Dimes grant of $35,837 will assist the Committee on Careers in Nursing to continue its program of recruitment of students for nursing education.

Since 1949, the National Foundation for Infantile Paralysis has provided financial assistance to the committee, which is supported by national nursing, medical and hospital organizations along with other professional and business groups. The foundation has also carried on an intensive recruitment program. For the third year the grant will underwrite the committee's field services program to intensify the recruitment of students for both professional and practical nursing schools.

In commenting on the March of Dimes grant, Theresa I. Lynch, chairman of the Committee on Careers in Nursing, National League for Nursing, said, "The present inadequate supply of nurses is a crucial problem to the National Foundation for Infantile Paralysis and to every individual or agency concerned with the care of the sick. The demand for nurses continues to exceed the available supply. At present, the estimated shortage of nurses for civilian needs alone is 50,000."

De Paul to Sponsor Audio-Visual Institute

An Institute on Audio-Visual Aids in Clinical Teaching will be sponsored by the Department of Nursing Education of De Paul University, Chicago, March 5-6, at the La Salle Hotel. Commercial and nursing school exhibits of audio-visual aids will be included.

Nation's Nursing Needs Theme of NLN Convention

"Concerted Action to Meet the Nation's Nursing Needs" will be the theme of the 1953 convention of the National League for Nursing to be held in Cleveland, June 22-26. Program meetings of interest to all nurses in all fields and positions and to other public-spirited citizen are being planned, acording to Margaret Losty, chairman of the committee on program.

Monday's program features meetings for special interest groups and industrial nurses, while general program sessions will be scheduled for Tuesday. Departmental meetings are on the agenda for Wednesday with an address in the evening by Dr. Alan Gregg, vice-president of the Rockefeller Foundation. More special interest groups will meet on Thursday.

Blue Cross Growth Hits Lowest Third Quarter

During the third quarter of 1952 the 87 approved Blue Cross plans experienced the lowest third quarter growth since 1939 with a net gain in membership of 291,592. This increase brought the net growth for the first nine months of 1952 to 1,393,624 members, the lowest net increase since 1940 for a comparable period.

The total membership in Blue Cross plans as of September 30, 1952, was 42,833,173 and consisted of 17,831,817 subscribers and 25,001,356 dependents.

Three plans changed size groups during the third quarter period. The Youngstown, Ohio, plan advanced from the 100,000-to-200,000 participants group to the 200,000-to-500,000 participants group. The St. Paul plan dropped from the 1,000,000 or more participants group to the 500,000-to-1,000,000 participants group, and the newly reorganized Montana plan, now located at Great Falls, dropped from the 50,000-to-100,000 participants groups to the less-than-50,000 participants group.

Two plans (Newark and Detroit) acquired a net of more than 50,000 new members during the quarter. Newark led all plans with a net growth of 77,860 members and Detroit showed a net gain in membership of 53,786.

Based on the U. S. Census Preliminary Count by counties as of April 1, 1950, and the area served by each plan as shown in the *Blue Cross Manual*, 10 plans have enrolled more than 50 per cent of the population served in their respective areas as of September 30, 1952. The four plans leading in per cent of population enrolled are: Allentown, 77.28 per cent; Providence, 75.59 per cent; Cleveland, 65.73 per cent; and Washington, D. C., 65.61 per cent. The national average of population enrolled by the 87 Blue Cross plans rose from 26.41 per cent to 26.59 per cent during the third quarter period.

Private Medical Expenses Reviewed in Bulletin

In 1951 private insurance met about 13 percent of the personal costs of sickness, leaving 87 percent to be met individually, according to a report released recently by Arthur J. Altmeyer, commissioner of the Social Security Administration.

The combined total of private expenditures for medical care and the loss of income due to sickness was 14.2 billion dollars. The nation paid 2.4 billion dollars in premiums for insurance against these private sickness costs and received back 1.8 billion dollars in benefits. The difference of 600 million dollars, the net cost of the insurance, equalled one-fourth of the premiums or one-third of the benefits.

The report, covering each of the four years 1948-1951, appears in

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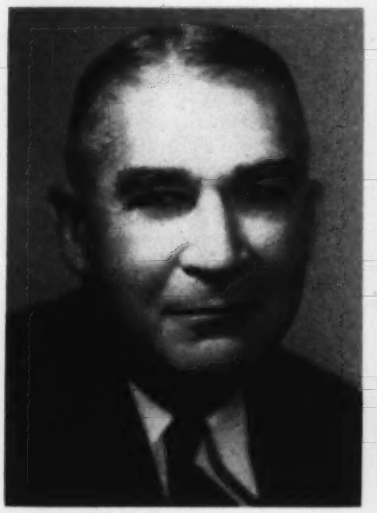
the *Social Security Bulletin* for December 1952. It shows the details of private expenditures for all kinds of medical services and commodities, estimates of income loss due to sickness, and the premium income and benefit payments for all kinds of private health insurance.

Louis H. Pink Retires from New York Blue Cross Post



Louis H. Pink, chief executive of Associated Hospital Service, New York's Blue Cross Plan, for the past ten years, retired as chairman of the board of directors January 1. He will continue his association with Blue Cross in an advisory capacity. Charles Garside, who succeeded Mr. Pink as president of Associated Hospital Service in July 1950, will serve the organization as president and chairman of the board.

Before Mr. Pink became president in 1943, he was superintendent of insurance of New York State for eight years. During his term of office at Associated Hospital Service, he encouraged enrollment by liberalizing benefits to meet the public need for more comprehensive health insurance. He also urged the creation of United Medical Service, now the largest Blue Shield plan in the United States.

On leaving the Associated Hospital Service, Mr. Pink will continue his activities in housing, insurance, economics, education, and welfare fields. He is president of Queensview, a cooperative housing development for middle-income families.

Mr. Pink is chairman of the Citizens Conference on Inter-

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national Economic Union. Among the organizations he serves as a director are the Mutual Life Insurance Company of New York, the National Foundation for Infantile Paralysis, St. Lawrence University, Georgia Warm Springs Foundation, and the Citizens Housing and Planning Council.

Mr. Garside, the new president of the Associated Hospital Service, is former chairman of the New York state commission against discrimination. He is a member of the board and former acting president of the State University of New York. He is a director of numerous corporations and is active in civic and educational organizations.

During Mr. Pink's term of office at Associated Hospital Service, Blue Cross enrollment increased from 1,250,000 to 5,188,000. Subscription income was nearly $11,000,000 in 1942 and by the end of 1952 the combined income of New York's Blue Cross-Blue Shield was expected to exceed $100,000,000.

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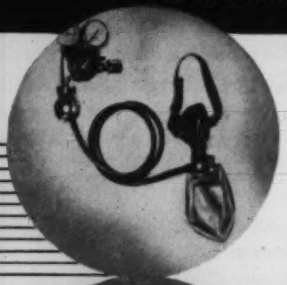

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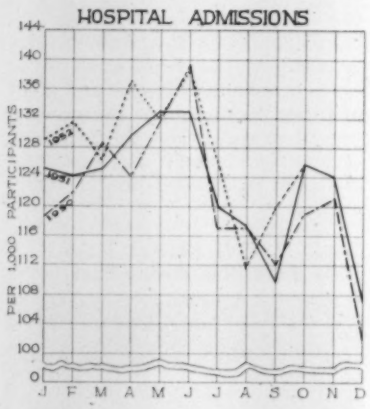
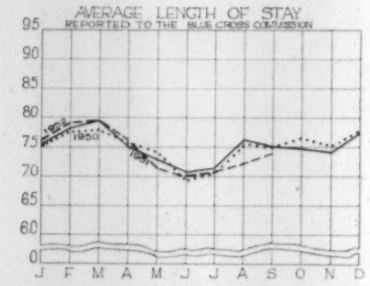




ADMISSION-STAY

During October 1952, Blue Cross plans experienced identically the same annual rate of hospital admissions as during October 1951, when a new high for the month was reached.

The admission rate during October 1952 was 126 inpatients per 1,000 participants. This marks an increase of five per cent over the experience of September.

The average length of stay experienced by the Blue Cross plans during September 1952 reached a new low for the month with 7.38 days per hospital stay. This represents a decrease of .14 days when compared to September 1951 and a slight increase of .04 days over August 1952.

Contrary to the decreasing trend of the past three years, the number of inpatient days of care provided during September increased slightly over August and reached a new high for the month. The plans provided an average 858 inpatient days of care per 1,000 participants during September 1952. This represents an increase over the previous month of only two days per 1,000 participants and an increase of three days per 1,000 participants over the same month one year ago. This experience marks the least fluctuations in September inpatient days during the last five-year period when compared to both the previous month and the previous year.

Kiwanians to Sponsor Cerebral Palsy Research

The basic problems of the deeper brain areas in cerebral palsy will be studied with new techniques over the next five years at Children's Memorial Hospital, Chicago, in a project financed by the Illinois-Eastern Iowa District of Kiwanis International. Kiwanians, who had been asked by their leaders to contribute $75,000 for the work, responded with pledges totalling $82,000, and 15 of the 174 clubs have yet to report.

Hitherto most research on cerebral palsy has dealt with the care of patients, surgical corrections and the like. The deeper brain lesions, believed to be at the root of the condition, could not be studied satisfactorily. The development of a new stereotaxic instrument by Dr. Percival Bailey, professor of neurology and neurological surgery at the University of Illinois College of Medicine, has now made it possible to go safely into the brain to study such areas. Using x-ray control and the machine's coordinating mechanism, the research team can place electrodes in the brain to record brain waves in or to electrocoagulate any specific areas.

Such studies will be in addition to a detailed investigation of the patient's whole physical and mental being, including brain-wave studies, pneumoencephalograms which outline brain structure by means of air injections, and angiograms which study blood circulation in the brain.

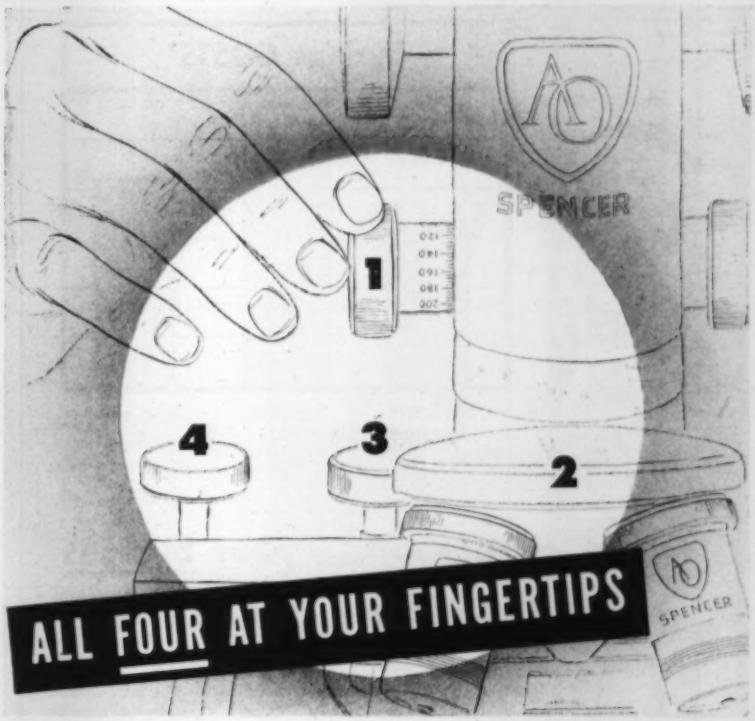
It is hoped that new methods of treatment may be devised eventually as a result of a more complete understanding of brain mechanisms and their relationship to spastic paralysis.

Congenital Heart Disease Target of Joint Program

Children living in the Middle Atlantic and Southern states who have congenital heart disease may benefit under plans worked out jointly by The Johns Hopkins Hospital, the Maryland State Health Department, and the U. S. Children's Bureau.

Dr. Martha M. Eliot, bureau chief, announced that Maryland has been designated as the fourth regional congenital heart program to be included in federal grants aimed to help provide surgical and hospital care for these children. Regional congenital heart programs previously approved are in New Haven (Conn.), Chicago, and a California program operating in San Francisco and Los Angeles. Since inauguration of the programs, expanded facilities in states within the New England area have made it possible for the program to be discontinued at New Haven.

Dr. Edward Davens, director of Crippled Children's Services, Maryland State Health Department, who submitted the state



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plan for participation in the regional heart program, said it will operate primarily on behalf of children from Pennsylvania, Delaware, West Virginia, Virginia, the District of Columbia, North Carolina, South Carolina, Tennessee, Alabama, Georgia, Florida, Mississippi, Puerto Rico and the Virgin Islands.

The Maryland program will be located at The Johns Hopkins Hospital.

The special Children's Bureau grant will be used primarily to give inpatient hospital care, including such extra items as special nursing and blood transfusions.

East Lansing to Be Site of Hospital Law Institute

February 4-6 have tentatively been set up as the dates for an institute on the legal aspects of hospital administration to be held at the Kellogg Center on the campus of Michigan State College, East Lansing. The first institute of this nature ever to be conducted in Michigan will have as its objective the stimulation of awareness by persons connected with hospital administration of their legal responsibilities and obligations.

The institute will center around legal responsibilities of the board of trustees; business law and the law of contacts in regard to personnel, purchasing and collections; workmen's compensation, law and decision, trends, secondary acts; and hospital responsibility for the acts of medical staff and employees. Other features of the institute are a mock trial and panel discussions dealing with subjects such as essential documents, liability for injury to others, liability for maintenance of a safe hospital and hospital insurance problems.

Dr. Colbert Appointed Dean

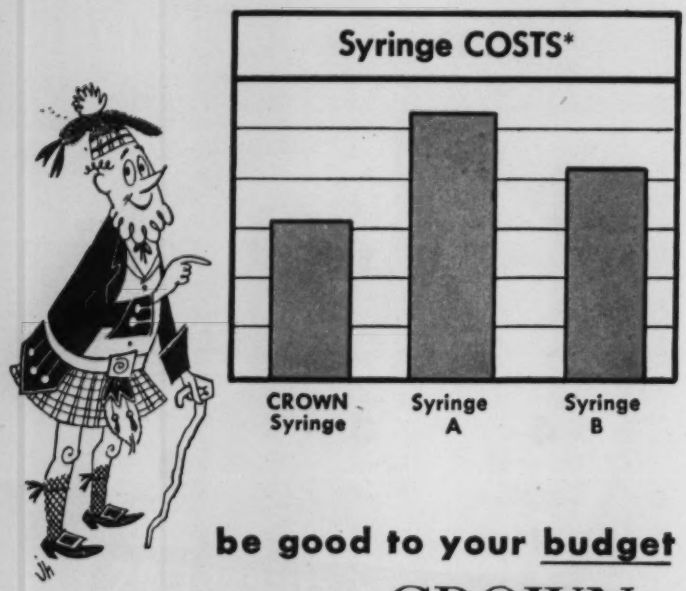
James W. Colbert, Jr., M.D., has been appointed dean of the Saint Louis University School of Medicine.

Dr. Colbert, who will assume his duties in March, will be the youngest dean of any major medical school in the United States. He was 32 years old on December 14.

Dr. Colbert comes to Saint Louis University from Yale University School of Medicine where he has been assistant dean in charge of post-graduate studies since 1951. He has also served as chairman of the university committee for post-graduate medical education and chairman of the postgraduate education committee of the Connecticut State Medical Society.

In 1950, he became assistant professor of medicine at Yale, associate physician of Grace-New Haven Community Hospital, and director of medical education of Middlesex Hospital, Middletown, Conn. From 1948-1949, he was assistant resident physician in the department of internal medicine at the Yale University School of Medicine, becoming instructor in the section of preventive medicine in 1949. That same year, he was appointed civilian consultant to the surgeon general of the United States Army and representative of the Armed Services Epidemiological Board.

Dr. Colbert received his bachelor of arts degree magna cum laude from the College of the Holy Cross in 1942 and received his doctor of medicine from the College of Physicians and Surgeons, Columbia University. He interned at



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Bellevue Hospital, New York City, in 1945.

He is a member of the Society of Sigma Xi, American Association for the Advancement of Science, New York Academy of Science, Society of American Bacteriologists, the New Haven Medical Association and the Connecticut State Medical Society.

AMA President Outlines Nine-Point Program

A nine-point program for "the preservation of our American system of medicine" was recently outlined by Dr. Louis H. Bauer, president of the American Medical Association. The nine points, directed to all physicians and all component societies, are as follows:

1. Work with rural communities to establish facilities for physicians for better distribution of physicians.
2. Make good medical care for the indigent available everywhere.
3. Extend public health coverage to areas lacking it.
4. Develop plans for the care of the chronic invalid.
5. Expand voluntary insurance program to cover more persons, those over age 65 and those suffering from illness of long duration.
6. Discipline physicians who are tarnishing the reputation of the whole profession by their unethical acts of overcharging, accepting kick-backs, and making commercial arangements with pharmacists.
7. See that the public is protected so that they can always obtain the services of physicians.
8. Revitalize our county societies and make them leaders in their communities in all health matters.
9. Inculcate the newly trained physicians in the tradition and ethics of medicine.

Dr. Bauer said the following legislative matters will require the attention and study of the AMA: the establishment of a department or independent agency of health in the federal government, making of constructive suggestions to solve the problem of the totally disabled under the social security law, obtaining sufficient physicians for the armed forces without injustices or upsetting civilian medical care programs and the enactment of a law allowing pensions or retirement privileges for the self-employed.

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Josie M. Roberts Retires

Josie M. Roberts, administrator of the 135-bed Methodist Hospital at Houston, has retired as of February 1. She will reside in Albuquerque, N.M.

Mrs. Roberts, an active leader in hospital administration for many years, will be succeeded by Ted Bowen, her assistant administrator. Mr. Bowen has been appointed acting administrator of the hospital.

Dr. Corwin Retires from Executive Secretary's Post

After 41 years of service E. H. L. Corwin, Ph.D., has retired as executive secretary of the Committee on Public Health Relation of the New York Academy of Medicine. Dr. Corwin will continue to serve the public health field for he is now a member of the executive staff of the Medical Society of the County of New York.

After college training, Dr. Corwin did his graduate work at Columbia University. He was awarded a university fellowship and subsequently the Garth fellowship. He received his degree of doctor of philosophy in economic, social and biological sciences in 1910. The next year he began his executive secretary position with the New York Academy of Medicine.

Much of Dr. Corwin's work has been related to hospitals. His first achievement was the exposure of the conditions in the contagious disease hospitals of New York City, a study that led eventually to great improvement. The next year he organized an Association of Outpatient Clinics, through which the first medical standards of dispensary work in New York City were developed. A few years later he directed the first comprehensive survey of dispensaries, the reports of which were published in various professional journals and led to the organization of the Committee on Dispensary Development.

In 1924 Dr. Corwin conducted an exhaustive survey of the hospital facilities in Greater New York; the report of this work became a model of its kind and a standard book in its field. During the ensuing years he has made many surveys of individual hospitals and of hospital service in various communities.

Dr. Corwin next became director for 12 years of the Bureau of Hospital information and Service. This agency was the forerunner of the present Hospital Council of Greater New York.

Dr. Corwin's participation in hospital work became international when, in collaboration with the late Dr. S. S. Goldwater in 1928 and 1929, he organized the first International Hospital Association. As secretary and treasurer of the Association, he directed its biennial congress, was a member of the editorial board of its journal, *Nosokomeion*, and later was made honorary president.

Dr. Corwin's publications include some 500 articles and reports and several books. His books include such diverse subjects as "The Hospital Situation in Greater New York," "The American Hospital," "Opportunities for the Medical and Public Health Education of Negroes," and "A Political History of Poland." Besides these, he has edited "An Outline of Preventive Medicine in Modern Medical Practice," "Ecology of Health," "Infant and Maternal Care in New York City," "Convalescence and Rehabilitation," and "Convalescent Care." The major portion of Dr. Corwin's periodical publications and reports have dealt with aspects of public health and hospital organization and administration and with convalescence.

Recently Dr. Corwin directed a survey of the health needs of Greater New York, sponsored by the Health Council of Greater New York, in cooperation with the academy and other groups. A part of this survey was a study of infant mortality, the first report of which recently appeared under the title "Infant and Maternal Care in New York City."

Court Rules for Osteopaths

Osteopathic physicians have the right to practice in Missouri's county hospitals the St. Louis Court of Appeals recently ruled in a case initiated by the hospital board of Audrain County and the Missouri State Medical Association. The decision upheld three of the findings of the Circuit Court of Audrain County. The three findings are:

1. The rule adopted by the plaintiff Board of Trustees of the Audrain County Hospital dated February 27, 1940, excluding doctors of osteopathy from practicing in the Audrain County Hospital is illegal, unreasonable, discriminatory, void and of no force and effect.

2. Osteopathic physicians and surgeons are practitioners of a school of medicine and are physicians and surgeons within the meaning of the Missouri statutes regulating their practice rights.

3. Osteopathic physicians and surgeons are entitled to take their patients to the Audrain County Hospital for treatment, subject to reasonable rules and regulations promulgated by the Board of Trustees of this hospital.

Volume of Medical History Published by Army

The Army has announced the publication of "The Physiological Effects of Wounds," the first book in a series of 34 volumes on the history of the United States Army Medical Service during World War II. Data in this text is the first medical research ever conducted by the Army on the front lines.

Board members gathered the material by studying severely wounded men in the North African-Mediterranean theater of operations. Board members frequently worked on the battlefield, examining seriously injured men minutes after they had reached forward battalion aid stations.

Principal objects of study were shock and resusciation. From observation of 186 wounded patients, the research men collected positive evidence of the superiority of whole blood transfusions as compared with blood plasma. The first clinical observations of kidney shutdown were also made.

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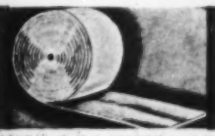

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INSTITUTES

(Continued from page 6.)

Institute on Front Office Procedures (in conjunction with Mid-West Hospital Association)—April 13-14; Kansas City (President Hotel).

Institute on Operating Room Administration (in conjunction with Tri-State Hospital Assembly) — May 5-6; Chicago (Knickerbocker Hotel).

Institute on Safety (in conjunction with Tri-State Hospital Assembly)—May 7-8; Chicago (Palmer House).

Institute on Hospital Laundry Management — May 11-12; Minneapolis (Radisson Hotel).

Institute on Central Sterile Supply (in conjunction with Middle Atlantic Hospital Assembly) — May 18-19; Atlantic City (Claridge Hotel).

Institute on Hospital Pharmacy — June 15-19; Los Angeles (Loyola University).

Institute on Anesthesia—June 22-26; Boston (Somerset Hotel).

Institute on Public Relations—June 29-July 3; Princeton (Princeton University).

Institute on Purchasing — October 19-23; Philadelphia (Penn Sheraton Hotel).

Institute on Dietary Department Administration — October 26-30; New York (Park Sheraton Hotel).

Institute on Supervisory Training—November 2-6; Chicago (Edgewater Beach Hotel).

Institute on Laundry—November 9-13; New York (Park Sheraton Hotel).

Institute on Housekeeping — November 16-20; Boston (Somerset Hotel).

Institute on Nursing Service Administration December 7-11; New Orleans (St. Charles Hotel).

Medical Education Fund To Solicit $5,000,000

The National Fund for Medical Education has begun a $5,000,000 industry-wide solicitation campaign in support of medical education in the United States, announced Colby M. Chester, newly appointed chairman of the fund's Committee of American Industry.

Mr. Chester will direct a nationwide fund-raising organization to mobilize America's business concerns behind the nation's hard-pressed medical schools. Medical school deficits totaling $10,000,000 annually are seriously threatening medical training standards, it is reported.

The Committee of American Industry, which will spearhead the campaign, will be composed of 100 ranking business leaders from every part of industry. Their job will be to educate industry as to the critical needs of the medical schools and the schools' importance in keeping production lines going.

Average Physician Income Was $15,262 in 1951

The average physician in private practice had a 1951 net income, before taxes, of $15,262—a rise of 35 per cent in four years, it was revealed in the December issue of *Medical Economics*, national business magazine for doctors.

According to a survey of its 134,000 physician readers, the average United States doctor is in a better financial position now than at any time in the past. But physicians' incomes vary widely when regional and other breakdowns are made. The farther west a doctor practices, says the report, the higher his income is likely to be. Physicians in New England and the Middle East have the lowest incomes in the country, while those in the Far West have the highest.

The table below gives the average 1951 net incomes by regions:

New England	$12,158
Middle East	12,938
Southeast	16,048
Southwest	15,947
Central	16,928
Northwest	16,431
Far West	17,900

Doctors' incomes tend to be highest in cities of 50,000 to 500,000 population, and lowest in cities of more than 1,000,000. Of the 10 largest cities in the country, Cleveland and St. Louis show the highest incomes, and New York, Philadelphia, Boston the lowest.

The magazine also found that incomes are generally highest among medical men with 10 to 20

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years in practice. They are lowest among those with 30 or more years of experience.

Boston Hospital Adds Doctors, Administrator to Its Board

The Massachusetts Memorial Hospitals, Boston, in action designed to meet the changing role of the hospital in the modern community, has added to its board of trustees the administrator and the chiefs of its several medical services. The move has given the executive heads of all its divisions "full, responsible partnership in the determination of hospital policy."

Administrator of the hospital is Dr. Philip D. Bonnett.

In announcing the break with tradition, Jerome Preston, president of the hospital's board of trustees, said it was made necessary by "a new mutuality of interest between physician and hospital."

"The hospital has always been dependent on the physician for the medical care rendered within its walls," he said. "The physician is now dependent on the hospital for the technical services that are available usually only within its walls. The doctor's black bag has been replaced by the equipment and supplies within the hospital."

In setting up for the first time a hospital organization structure which parallels that of a typical business corporation, Mr. Preston said, his board had recognized that while the aims of doctors and trustees were essentially the same in the long run, they were often in conflict on immediate problems.

"We see our hospital in one important aspect as big business—in our case, nearly $3,000,000 a year. We think it not inconsistent with our charitable purpose to try to apply the organizational methods and techniques developed and proved by business. We recognize that our staff and administrator are going to make our institution a success or failure. The trustees can select and remove these men but they cannot mop up after them from day to day. It strikes me as illogical in the extreme not to have them participating with full responsibility in the deliberations where policy is made."

Mr. Preston said that many of the objections to the change were "outdated," that is, they related to a hospital with a purely voluntary staff, rather than a teaching hospital where many of the top men are fulltime employees.

Omaha Officials Propose Extensive Building Plans

Building programs totalling $10,000,000 have been proposed by Omaha hospital officials. Building projects already undertaken include: Remodeling the rooms, expansion of the clinical laboratory, and improvement of x-ray facilities at Doctors Hospital; a $750,000 addition of an 80-room wing to the Methodist Hospital, and the establishment of a tuberculosis ward at the Veterans Hospital.

Two $1,000,000 fund drives have been inaugurated for additions to Bishop Clarkson and Immanuel Hospitals. Programs proposed were: $6,000,000 building program for University Hospital, the construction of a 200-bed hospital at the University of Nebraska College of Medicine, and the remodeling of Clearview into a hospital for the critically ill.

Polio Nursing Conferences Planned for Early 1953

The nursing advisory services for orthopedics and poliomyelitis of the National League for Nursing plan to participate in a series of 12 work conferences on the nursing care of polio patients this year. These conferences, which will be held throughout the country, will begin in February and continue during March and April.

The purpose of the meetings is to help nurses responsible for nursing services, administration of polio units, home care programs, and representatives of nursing education to incorporate the newer methods and trends in their total programs of nursing in the home, hospital or school.

Attendance at the conference will be limited to key personnel in hospitals, schools of nursing and public health agencies. The last two days of each conference, however, will be open to directors of nursing services and directors of nursing education programs not present during the early part of the conference, and to hospital administrators so that the total field of nursing for patients with polio may be explored and planned.

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Chicago Hospital Installs New Heart Station

A new heart station has been established at Wesley Memorial Hospital, Chicago, to provide expanded facilities for exploring heart diseases.

Dr. Gerald R. Graham, formerly associated with Western Reserve University in Cleveland, has been appointed director of cardiovascular research and placed in charge of electrocardiography at the hospital with the responsibility of setting up and directing the heart station.

With the new facilities, Wesley will be able to serve an increased number of heart patients requiring special tests. One such test is cardiac catheterization for congenital and rheumatic heart disease victims.

New Ways of Treating Joints, Bones, Discussed by Surgeons

The treatment of bone and joint tuberculosis, fractured hips, and arthritic joints were some of the topics discussed at the twentieth annual meeting of the American Academy of Orthopaedic Surgeons in Chicago January 24-29.

During the session prominent specialists in orthopaedic surgery discussed the following:

1. Los Angeles physicians declared surgery is the method of choice in the treatment of fractures of the hip among elderly persons. The operative method, internal fixation, "reduces mortality, simplifies the nursing care, adds materially to the comfort of the patient, shortens the hospital stay, makes it possible for the patient to be out of bed sooner, increases the number who are restored to full weight-bearing, and lengthens the survival rate."

2. The ingrown toenail was Dr. David I. Schwartz's topic. Contrary to popular belief, Dr. Schwartz said that, as a rule, an ingrown toenail does not result from improperly fitted shoes or stockings or faulty foot balance, but to improper trimming of the nails.

3. Four surgeons from the Robert B. Brigham hospital in Boston related the new surgical technique of using a nylon sheet or membrane on arthritic knee joints to improve motion.

4. The injection of a new drug, hyaluronidase, into an injured sprained ankle reduces swelling and relieves pain within two hours, declared Dr. W. R. MacAusland Jr. of the United States Air Force Hospital, Maxwell Air Force Base, Alabama.

5. Bone that is preserved by freezing in hospital bone banks is better than bone preserved chemically, according to a recent survey of academy.

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Los Angeles—Midway Hospital
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San Diego—Childrens Hospital, San Diego Society for Crippled Children

FLORIDA
Milton—Santa Rosa Hospital
Winter Park—The Memorial Hospital Trust Association

ILLINOIS
Dolton—Thomsen Clinic Hospital

MARYLAND
Glenn Dale—Glenn Dale Tuberculosis Sanatorium
Rockville—The Christ Child Farm for Convalescent Children

MICHIGAN
Detroit—Plymouth General Hospital

NEVADA
Reno—St. Mary's Hospital

NEW YORK
Schenectady—St. Clare Hospital

NORTH CAROLINA
Boone—Watauga Hospital

OKLAHOMA
Stilwell—Stilwell Municipal Hospital

PENNSYLVANIA
Lewistown—F. W. Black Community Hospital
Philadelphia—Olney Hospital & Lawncrest Diagnostic Clinic
Scranton—Moses Taylor Hospital

TEXAS
Edinburg—Grandview Hospital
Fort Worth—W. I. Cook Memorial Hospital Center for Children
Midland—Midland Memorial Hospital

WYOMING
Torrington—Lutheran Hospitals & Home Society

CANADA
Belleville, Ontario—Belleville General Hospital
Outremont, Montreal, P.Q.—Comite Des Hopitaux Du Quebec
Tisdale, Saskatchewan—St. Therese Hospital

PUERTO RICO
Aguadilla—Aguadilla District Charity Hospital
Arecibo—Arecibo District Hospital
Bayamon—Bayamon District Hospital
Fajardo—Fajardo District Hospital
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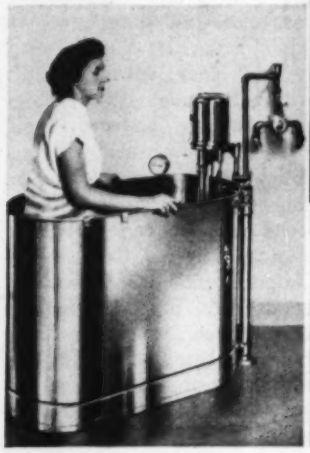

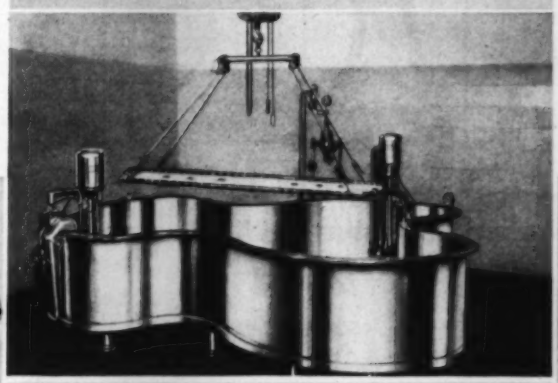

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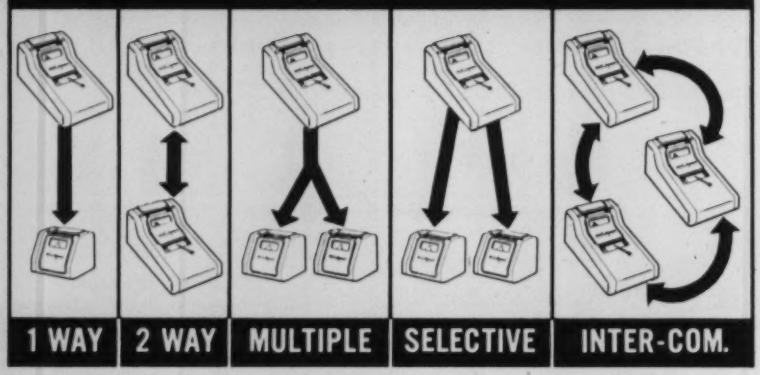

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HOW TO DETERMINE HOSPITAL COSTS

(continued from page 71)

students from other schools of nursing at the Swedish Hospital.

2. The total income from the professional school of nursing has been taken from accounting records and calculated from a study of student effectiveness carried on by the nursing school office of the Swedish Hospital. The value of the student nurse to the hospital has been determined and this has been credited to the income account of the Professional Nursing School.

3. Students on affiliation from the Swedish Hospital school of nursing to other institutions essentially provide neither income nor expense during their affiliation period.

4. The total number of enrolled students in the Swedish Hospital school of nursing is the basic figure used in the calculation of the average cost per professional student during 1951.

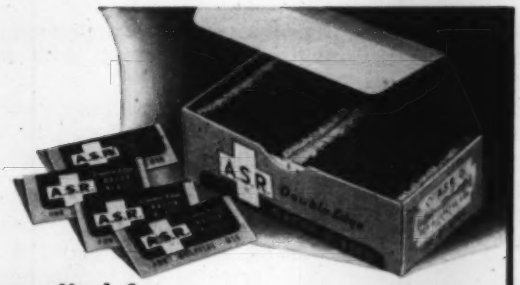
Total expenses	$297,094.35
Total income	179,506.11
Net cost to hospital	$117,588.24

From this total cost of the Professional Nursing School, a figure giving the average cost for each student enrolled in the school can be calculated.

Average enrolled students	183.92
Net cost to hospital	$117,588.24
Average cost per student	$ 639.36

The results of this study of the cost of operating the school of nursing during 1951 has resulted in the first clear picture of just what it really does cost the hospital to educate a professional nurse. The information serves as a valuable guide to administration and the governing board in making broad decisions concerning the school of nursing

As Superintendent Ray Swanson points out in the preceding article, one big decision already has been made: Despite the cost, the Professional School of Nursing at the Swedish Hospital will continue to operate.



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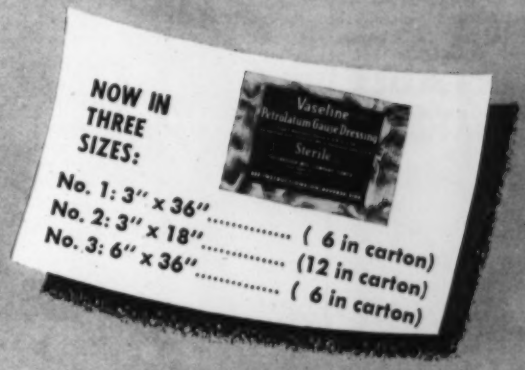
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PRO RE NATA

JOHN H. HAYES

Budget calculators again have a tough time of it. In recent years they have had to be soothsayers. If they would take into consideration the campaign speeches of both parties in the recent election even soothsayers would get confused in figuring 1953 costs.

Most columnist engage in predicting. Why shouldn't I? My guess is that the November, 1952, patient-day costs, plus 3 per cent will prove to be the average patient day costs in general hospitals over the year we have just entered.

Some might ask how I reached this conclusion.

Due to the low census in December, I used November as an average month at approximately the high level in payroll and supply costs; and added 3 per cent merely as a guess, because I feel we have about reached the top of the inflationary era. Then I just started to pray that this will prove to be true.

Inasmuch as I am not posing as an expert on this subject, if I am eventually shown to be wrong, I can still try again for 1954.

★ ★ ★

Although not a fresh-air fiend I like my office to be cool. At this season I am often accused of keeping the office cold so that visitors to my desk do not stay long. Some have accused me of wearing red flannels under my suit so that I can stand it, while they cannot.

The system seems to pay off in adding to my free moments during the day, even though not so intended.

★ ★ ★

I think that a great many of us are pleased with the selection of Mrs. Oveta Culp Hobby as Federal Security Administrator. That is one of the most important departments in our government; and its importance grows day by day. Hospitals have more to do with that department than with any other.

I am glad that we have a handsome fellow as chairman of the Council on Government Relations —Bill McNary.

★ ★ ★

At this season up North I think about how different our patients' ailments are from those in Southern hospitals. Because of the ice, skiing and skating we no doubt have many fracture cases which our Southern hospitals do not have to treat. Of course people fall out of trees, etc.; but not as often. I then wonder whether orthopedists think of this and try to practice in cold climates.

I went skiing in the Laurentians some years ago, when I had less sense, and at each railroad station they loaded on men and women in splints, after a weekend of sport.

There is probably great truth in the saying that skiing is for Norwegians and children.

★ ★ ★

In smaller communities this might be a good suggestion:

Through an attorney on your board of trustees you could learn about the proper procedure to bring about a meeting at which the lawyers of the community could listen to someone who could tell them all about the hospital and its needs.

Lawyers not only draw wills, but they can and do advise people on income tax matters. They can make it possible for you to receive large sums which might otherwise be lost.

Those who practice law can be most helpful in money-getting for hospitals.

★ ★ ★

I wish someone would invent a hospital bathrobe for the use of ward patients that could withstand frequent laundry washings without soon appearing as though made from potato sacks.

★ ★ ★

With shortening of the average stay of hospital patients many of us should reanalyze our figures on beds needed now or in the future.

For instance, a 200-bed hospital operating at 80 per cent occupancy would give about 60,000 patient

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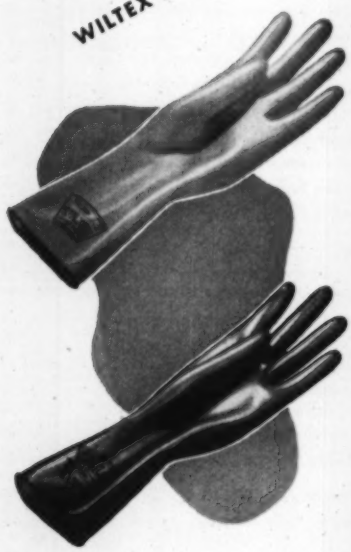

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days of service in a year. If the average stay were 15 days that would mean that 4,000 people had used the hospital's facilities. If the average stay were reduced one-third, or 10 days, the hospital would serve 6,000 people, without overcrowding and still operating at 80 per cent of capacity. In other words, in effect, the 200 bed hospital would become a 300 bed hospital.

In the near future I believe we are going to learn more about home care, and other procedures which will shorten the hospital stay. In the meantime hospital planning should include much flexibility, to provide for seasonal closing of patient facilities, possible use for convalescents or those with chronic illnesses, etc., thus meeting changing needs and keeping down costs.

* * *

Many hospitals—including my own—have, over the past two years, broadened their visiting hours and rules. I think all of us have found it worthwhile. It is apparent that when hours and number of visitors are not greatly restricted people are less likely to come too often or stay too long. Patients are not subjected to crowds for a short period, always fatiguing, and the work of the hospital proceeds with perhaps less interruption. It seems to bear out the weakness in human nature—desire for all we can get of what is scarce and lack of interest in those things that are plentiful.

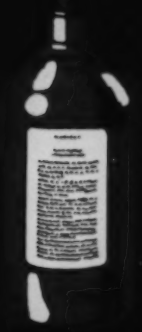
* * *

No one likes to be subjected to a means test—even when he makes out his income tax report.

I would not want to be a ward admitting clerk in a hospital. It's a tough job.

* * *

I think of others, such as "Maternity Supervisor," instead of "Supervisor of the Maternity Department." "Head Nurse"—should she take care of skull fractures, etc.? And there is nothing "special" in the diets that come out of special diet kitchens. Some of it tastes awful.



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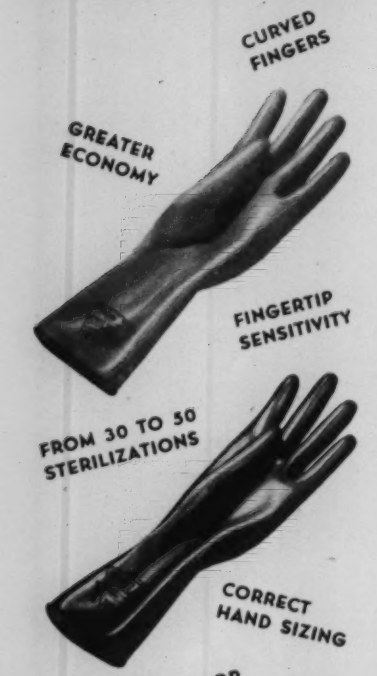

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EXECUTIVE HOUSEKEEPERS: (a) Large teaching hospital; competent assistant & staff of 50; will have department head status; prefer man; consider outstanding woman; around $6000; Midwest. (b) 600 bed teaching hospital; male or female; large city; South. (c) Brand new gen'l hospital 375 beds; large city; East. (d) Assistant; under 50; able type; 700 bed general voluntary hosp; city 500,000; Central.

FACULTY APPOINTMENTS: (a) Educational Director; University School; woman of outstanding attainments; Masters or PhD; qualified direct entire program; faculty appt. (b) Educational Director; mature woman with extensive experience & Masters to direct educational program; NNAS; voluntary general hospital 450 bds; commuting distance 2 medical schools; central. (c) Director, Nursing Ed; separate dep't; gen'l hosp 350 bds affil with univ offering BS in nursing degree; 200 students; substantial sal; lge city of south. (d) Educational Director; qualified psychiatric nursing; one of best equipped mental hospitals in tropical island of American dependency; mild climate. (e) Qualified as Coordinator of Clinical Instruction; gen'l hosp fairly lge size; lge city, Fla. (f) Clinical Instructor in obstetrical nursing and, also, Clinical Instructor in medical-surgical nursing; voluntary gen'l hosp 400 bds; NNAS; oppty continue studies; univ med center; central. (g) Nursing arts instructor; voluntary general hospital, 175 beds; university city near NYC.

SUPERVISORS: (a) Central Supply; capable supervising 10 employees and exper'd in all sterilization techniques; brand new dept; voluntary general hospital 350 beds; Midwest. (b) Clinical; voluntary gen'l hosp; 200 students; to $400; large city; univ med center; Central. (c) Administrative Nursing Supervisor; responsible to assistant director nursing ser; lge teaching hospital; $3900; 3½ room apartment near Lake; $55; Chicago. (d) Obstetric Teaching Supervisor; voluntary gen'l hosp 175 bds; university city near NYC. (e) Operating Room Supervisor; qual to supervise program 5000 operations; important general hosp; $350; near NYC. (f) Operating Room Supr; university hospital; $355; large city; South. (g) Orthopedic Teaching Supr; crippled children's hospital unit of large voluntary gen'l hosp; near Lake Erie; Ohio. (h) Pediatric; Complete charge pediatric division; about $350; city 400,000; univ med center; East.

MEDICAL RECORDS LIBRARIANS: (a) Chief; newly organized dept; voluntary gen'l hosp 120 bds; $400; one of larger towns; Alaska. (b) Chief; department staffed with 7 well trained employees; general voluntary hospital 300 bds affiliated medical school; large city; S. (c) Chief; staff of 5; fairly new modern vol gen'l hosp; 175 beds; near San Francisco. (d) Competent experienced woman to direct department; staff of 50; unit system; teaching hospital 600 bds; large city; univ med center; S.

THERAPISTS: (a) Occupational Therapist qualified to direct rehabilitation center; college town 175,000 near Chicago; around $6000. (c) Physical Therapist, Occupational Therapist; qual to assume responsibility in cerebral palsy rehabilitation foundation; will affiliate with teaching hosp & univ med school; Chgo area.

THE MEDICAL BUREAU
Burneice Larson, Director
Palmolive Building
Chicago, Illinois

ADMINISTRATORS: (a) Medical; to direct program of philanthropic organization; broad program of improving medical care; medical center and group of affiliated hospitals; opportunity faculty appointment. (b) Medical director and associate superintendent; large teaching hospital; medical center. (c) Lay or medical, to succeed administrator, 350-bed hospital retiring after long tenure; university city, East. (d) Director, group of minimum eight to ten hospitals, 50 to 200 beds, within radius 150 miles, currently under construction; able organizer required. (e) Lay; general hospital, 100 beds, expansion to 200 or 250 within ten years; Pacific Coast. (f) Lay; outstanding business ability required; relatively new hospital, 300 beds; Southwest. (g) Assistant director; new hospital, 300 beds; resort city, South. (h) General hospital; patient average, 250; Canada. (i) Assistant; minimum four years' experience, accounting background required; 225-bed hospital; resort town, Midwest; $7500-$8000. H2-1

ADMINISTRATORS-NURSES: (a) Voluntary general hospital, 75 beds; suburban location, East; $7500. (b) Small general hospital recently completed; summer resort town, near large city, university medical center, Midwest. (c) Assistant administrator; new orthopedic hospital, 85 beds medical center, West. H2-2

ANESTHETISTS: (a) General 200-bed hospital; university town; $450-$500, maintenance. (b) Association, group 15-Board men; $6000-$7200; Midwest. (c) Association, group, medical anesthesiologists; winter resort city, Southwest. (d) Hospital operated under American auspices, Latin America; knowledge Spanish desired, not required. H2-3

DIETITIANS: (a) Chief and assistant; general hospital, 150 beds; university town, near New York City; $4800 and $3000 respectively, maintenance included. (b) Chief and assistant dietitians; university hospital, new building under construction, completion 1954; outstanding dietary department; minimum salaries: $5400 and $3700 respectively, West. (c) Nutrition adviser, large industrial company; duties entail individual employee consultations, planning and construction of nutrition exhibits, training administrative dietetic interns; East. (d) Dietitian

MEDICAL BUREAU—(Cont'd)

for girls' unit serving 175 per meal; also dietitian for men's dormitory serving 700 per meal; large university; Middle West. (e) Chief; voluntary general hospital; average patient census 150; department well staffed; expansion program. California. H2-4

DIRECTORS OF NURSES: (a) Voluntary, general hospital, 300 beds, serving population 65,000, few miles from two important medical centers; excellent school; East. (b) Voluntary general hospital, fairly large size; considered one of California's leading hospitals; oustanding woman required. (c) Voluntary general hospital, 250 beds, 100 students; $6000, maintenance, private apartment; university town, East. (d) Nursing service only; new hospital, 300 beds currently under construction; teaching affiliation; university medical center, Midwest. (e) Associate director; voluntary general hospital; patient average 200; resort city, Southwest. H2-5

EXECUTIVE HOUSEKEEPER: Important teaching hospital; university center; $4200, maintenance; slight preference for man. H2-6

EXECUTIVE PERSONNEL: (a) Personnel director; 450-bed hospital; college town, East. (b) Purchasing agent; new hospital, 250 beds; suburban location, Midwest. (c) Chief accountant; 400-bed hospital; university center. (d) Public relations director; important hospital, vicinity; Chicago. (e) Office manager; 65-man group operating own hospital 300 beds. H2-7

FACULTY APPOINTMENTS: (a) Educational director qualified psychiatric nursing; university school interesting city outside Continental United States; although tropical country, climate mild. (b) Educational director; recently established collegiate school; $5000-$6000; California. (c) Clinical instructors, medicine and surgery; 200-bed hospital; college town, New Jersey; minimum $4600. (d) Nursing arts and clinical instructors; small school; university town, Midwest; minimum $4000. (e) Educational director; Pacific Islands. (f) Three teaching supervisors to coordinate in-service teaching program on team basis; fine hospital, relatively new; California; travel from Chicago refunded. H2-8

MEDICAL LIBRARIAN: To take charge new library, university medical school; Northwest. H2-9

RECORD LIBRARIANS: (a) Chief; large general hospital affiliated medical school; staff of fifty; South. (b) Chief; staff of 12; 500-bed teaching hospital; $5000-$6000. (c) Chief; large general hospital affiliated university medical school; large city, university medical center, West. H2-9

SOCIAL WORKERS: (a) Director psychiatric social work; child guidance center established 1949; $5200-$6200; East. (b) Social service director; voluntary, well endowed hospital for children currently under construction; resort city, Southwest. H2-10

STAFF NURSES: (a) Several; voluntary general hospital, relatively new; opportunity continuing studies; university town, California; fare from Chicago refunded. (b) New hospital, foreign plant, large company; $350, plus living allowance $220. H2-11

SUPERVISORS: (a) Floor; voluntary general hospital; fairly large size; San Francisco area; $350. (b) Operating room; large general hospital; Chicago area; minimum $400. (c) Obstetrics; new 300-bed hospital; collegiate school later; university town, Southwest. (d) Central supply, outpatient, obstetrics, operating room; new hospital, now being built; completion March; suburban town, East. (e) Assistant operating room; general hospital; West Indies. (f) Pediatrics; university hospital; apartment provided, beautiful new residence; large city, leading medical center. H2-12

ZINSER PERSONNEL SERVICE
79 W. Monroe Street
Chicago 3, Illinois

NURSES, TECHNICIANS, DIETITIANS, PHYSICIANS, NURSE SUPERINTENDENTS and INSTRUCTORS—We can help you secure positions.

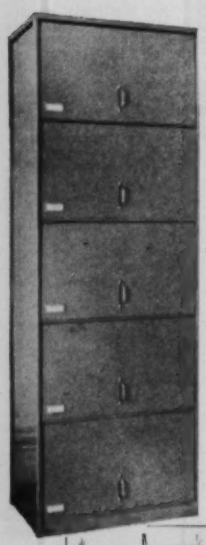
SHAY MEDICAL AGENCY
55 East Washington Street
Chicago 2, Ill.
Blanche L. Shay, Director

CLINICAL PSYCHOLOGIST: Capable developing training program for psychology interns; 60 bed institution for psychiatric care only; midwest; $4800 minimum.

DIETITIANS: (a) Administrative; 200-bed approved hospital, midwest; $5200. (b) Chief; southeast; 175-bed fully approved hospital; $3600 minimum. (c) Therapeutic; 400-bed hospital in process of rebuilding dietary department; Southeast; $4380. (d) Chief; 75-bed general hospital; Southwest; $4800. (e) Assistant; teaching hospital having new dietary department with complete, modern facilities; Southwest; $3600.

DIRECTORS OF NURSES: (a) Pacific Coast; 150-bed hospital; requires five years experience as director in hospital of comparable size, or as assistant in larger hospital; ideal year around climate; $6000. (b) New England; 250-bed hospital in city of 65,000. M.S. degree required; $7200. (c) Southeast; 250-bed hospital in heart of winter resort area; permanent; $6000 maintenance; M.S. required. (d) Assistant; large new hospital; South; $4800.

HOUSEKEEPERS: (a) Male Executive Housekeeper; 400 bed eastern hospital. (b) Executive; 150-bed general hospital, facilities complete and modern, eastern city of 15,000; $3600 to $4200 maintenance. (c) Executive, 225-bed hospital, pleasant community within easy commuting distance from Chicago; $3600 maintenance. (d) Executive; 265-bed hospital; capable of directing and administering complete housekeeping program; Midwest; $5200 maintenance. (f) Executive; 200-bed hospital located popular resort city; Southwest; $4200 maintenance. (g) Assistant; 150-bed hospital, modern, located city 100,000; Midwest; $3600 maintenance. (h) Assistant; 250-bed general hospital, complete modern facilities; East; $3600 maintenance. (i) Assistant; 200-bed general hospital, southwest city 50,000; $3600 maintenance. (j) Assistant; 300-bed



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general hospital, eastern city 50,000; $3600 maintenance.

NURSE ANESTHETISTS: (a) California; 35-bed hospital adjacent Los Angeles; $400 maintenance. (b) East; 165-bed hospital, city of 35,000; busy surgical service; $400 maintenance. (c) Southeast; 165-bed hospital, winter resort area; permanent, $500. (d) Middlewest; private group of specialists; $500. (e) Pacific Northwest; 75-bed hospital in town of 10,000, beautiful scenic country; good transportation to larger cities; $500 maintenance.

PHARMACIST: Midwest. 265-bed general approved hospital; 8 hour, five day week. $4000 up.

PHYSICAL THERAPISTS: (a) East. 400-bed hospital; supervising experience required; $4200. (b) Northwest; complete charge active physiotherapy department; modern, well equipped private clinic affiliated with 200-bed approved hospital; $4200 minimum to start. (c) East. 350-bed hospital, modern facilities; department supervised by American board member; $4200 up.

SOCIAL WORKER: Supervise active department, five social workers; 250-bed hospital with complete, modern facilities; $5200. West.

INTERSTATE
MEDICAL PERSONNEL BUREAU
332 Bulkley Building, Cleveland, Ohio

Miss Elsie Dey, Director

ADMINISTRATOR: 200 bed hospital, midwest; school of nursing. 100-bed addition being planned. (b) 300 bed specialized hospital, attractive eastern locality; residence provided.

ASSISTANT ADMINISTRATOR: 190 bed hospital, Ohio. Expansion program. (b) 200 bed hospital, Pennsylvania. (c) 150 bed hospital, near New York City. (d) 185 bed hospital, Kansas.

COMPTROLLER: 350 bed hospital, Connecticut. $6000. (b) 250 bed hospital, Massachusetts. (c) 125 bed hospital, Pennsylvania.

DIRECTORS OF NURSING. $4800-$6000, maintenance. (b) Assistant Directors; Educational Directors; Instructors — all specialties; collegiate schools included. To $5200.

DIRECTOR, COLLEGE RESIDENCES: East. Open June. (b) Executive Housekeepers. 250 bed hospitals, New Jersey, Pennsylvania, Ohio, Virginia.

DIETITIANS, Record Librarians, Anaesthetists, X-ray, Laboratory Technicians, Pharmacists. $400-$500.

VASSAR BROTHERS HOSPITAL
Poughkeepsie, New York

Fully approved—250 beds
Has following positions open.

EDUCATIONAL DIRECTOR. Experience and degree in nursing education, preferably M.S. Beginning salary $325 per month, with annual increment.

CLINICAL INSTRUCTORS FOR OPERATING ROOM AND PEDIATRICS, experience and advanced preparation, preferably degree required. Beginning salary $305 per month. Annual increment.

SUPERVISOR OF CENTRAL SUPPLY. Experienced and advanced preparation required, beginning salary $305 per month. Annual increment.

SUPERVISOR AND CLINICAL INSTRUCTOR FOR OBSTETRICS: experience and advanced preparation necessary, preferably a degree. Beginning salary $305 per month.

GRADUATE STAFF NURSES. Beginning salary $240 per month. Annual increment. This hospital is located 70 miles from New York City. It maintains a 40 hour week. Three weeks paid vacation. Sick time. Hospital care. Complete maintenance, if desired, at $45 per month. Apply Director of Nursing.

WANTED: Dietitian for floor duty. 300 bed hospital. Apply D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pa.

NURSE ANESTHETIST wanted to work in anesthesia department, general hospital. At present 4 nurses and 1 anesthesiologist. Salary $400 base, plus overtime. Contact C. G. Kramer, M.D. Beyer Memorial Hospital, Ypsilanti, Michigan.

SALESMAN WITH HOSPITAL CLIENTELE FOR SANITARY AND FLOOR CHEMICALS. EXCLUSIVE TERRITORY. COMMISSION. BRAM, 820-65th AVENUE, PHILADELPHIA, PA.

ANESTHETIST-NURSE. 600-bed approved general hospital; liberal personnel policy. Salary dependent upon experience. Apply, Personnel Director, Good Samaritan Hospital, Cincinnati 20, Ohio.

DIRECTRESS OF NURSES—300-bed fully approved general hospital with accredited school of nursing; located in a beautiful resort City; Personnel Policies in accordance with S.N.A. Degree in nursing education required; full maintenance, salary open. Apply Atlantic City Hospital. Atlantic City, N. J.

DIRECTOR—EDUCATIONAL: degree required; modern, fully air-conditioned hospital; fifty students, sciences taught at junior college. Range—$3600-$4800. Administrator, Greenwood Leflore Hospital, Greenwood, Mississippi.

DIRECTOR OF NURSING: 100 bed approved pediatric hospital; B.S. degree in nursing; full paid staff—graduates and practicals; nurses aide training programme; 40 hour-5 day week; personnel policies in accord with S.N.A.; excellent living accommodations. Salary open. Submit resume to Mr. D. O'Neill, Director, Babies' Hospital, 15 Roseville Ave., Newark, N. J.

PSYCHIATRIC SUPERVISOR—for 230 bed progressive private mental hospital. Brain surgery, electro-shock, insulin therapy. Five day week, 7 paid holidays, 10 days annual sick leave, 4 weeks paid vacation per year. Attractive living facilities if desired. Salary $280 to start. South Oaks, Amityville, Long Island, N. Y.

NURSES, REGISTERED (2) supervisory positions. One for evening and night duty relief; also one for 11 P.M. to 7 A.M.; 230 bed private psychiatric hospital; $280-$300 monthly, 5 night week, sick leave, vacation, 7 paid holidays. South Oaks, Amityville, Long Island, N. Y.

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DIRECTOR OF NURSING SERVICE WANTED for a beautiful, new 200-bed GENERAL HOSPITAL, preparing to open March 1, 1953. No school at present; will employ GRADUATE NURSES AND AIDES. Well organized MEDICAL STAFF, new and modern equipment, attractive working conditions; salary open. Also need OPERATING ROOM SUPERVISOR, FLOOR SUPERVISORS, HEAD AND GENERAL DUTY NURSES. APPLY TO WASHINGTON COUNTY GENERAL HOSPITAL, P. O. Box 3097, GREENVILLE, MISSISSIPPI.

RESIDENT PHYSICIAN—for active Thoracic surgery service. Salary commensurate with experience, includes maintenance. Tuberculosis Hospital. Apply State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

WANTED: Director of Nurses, 50 bed A.C.S. approved hospital in West Central Illinois. Forty-four hour week, social security, vacations, sick leave; attractive apartment available; salary open. Illini Community Hospital, Pittsfield, Illinois.

HOSPITAL ADMINISTRATOR — Experienced Administrator required for Regina General Hospital, 800 beds. Applicant should be experienced in hospital administration. Apply by letter giving full particulars, age, marital status, education, experience and salary expected to: The Chairman, Board of Governors, Regina General Hospital, Regina, Saskatchewan, Canada.

NURSES—Staff and Operating Room; 5 days, 40 hours; 8 holidays and vacation with pay; initial salary $230 plus laundry; increases at 6-12-24-36 months; additional pay for evening and night assignments and for Operating Room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, N. Y.

DIETITIAN: THERAPEUTIC, for 160 bed general hospital. Good personnel practices, attractive opening. Frederick Memorial Hospital, Frederick, Maryland.

ANESTHETIST-NURSE for fully approved 100-bed new hospital in Pacific Northwest. Two anesthetists regularly employed. Salary $350 per month plus complete maintenance. Apply Box D-86, HOSPITALS.

NURSE ANESTHETISTS — for 150 bed community hospital. Four nurses, full time M.D., all agents and techniques. Good opportunity for advanced training. Full maintenance and one month vacation. Two and one-half hours from Boston and New York. Write G. J. Carroll, M.D., William W. Backus Hospital, Norwich, Connecticut.

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Many positions available in most locations for Administrators; Anesthetists; all Technicians and all Nursing positions; Librarians; Dietitians; Housekeepers; Medical Secretaries; Pharmacists; Pathologists; Physicians; Radiologists; office positions. Send resume, 10 snapshots, date available.

WANTED: Instructor in Operating Room Technic, and Medical-Surgical Clinical Instructor. Fully approved 240 bed hospital with expansion to add 200 beds. Large student body. School of Nursing Nationally Accredited. University affiliation. Forty hour week. Staff Education. Salary open. Write HOSPITALS D-34.

EXCELLENT OPPORTUNITY for Clinical Instructors for approved School of Nursing. Four hundred bed general hospital. Special employee benefits. For details, apply Personnel Director, The Christ Hospital, Cincinnati 19, Ohio.

DIETITIANS: for ideally located 375 bed, fully approved general hospital. 1) for Food Production, 2) for modified diets and patient contacts. Salary good. 40 hour week. Three weeks vacation. Apply Director, Dietary Dept., Belmore & Terrace Rd., East Cleveland 12, Ohio.

EDUCATIONAL DIRECTOR: 200-bed general hospital, Southeastern United States with a school of nursing for 75-100 students. The school was founded in 1906. 4 weeks vacation, 12 working days sick leave. Leaves of absence for educational purposes. 45 hr. week. Salary open. A warm southern community offering the cultural advantages of a large city but maintaining friendly quiescence. Apply Box E-2, HOSPITALS.

DIRECTOR OF NURSES—135 bed hospital, modern, fully air-conditioned; school of nursing; degree required; $5000-6000. Administrator, Greenwood Leflore Hospital, Greenwood, Mississippi.

NURSE ANESTHETIST—for 122-bed General hospital, 44 hour week; no night calls; salary open. Write Administrator, Mary Washington Hospital, Box 558, Fredericksburg, Virginia.

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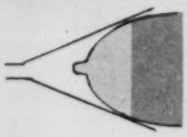

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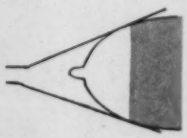

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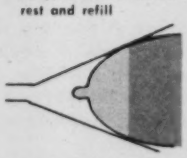

• Suction again draws out milk.

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Easy to clean—cannot contaminate.
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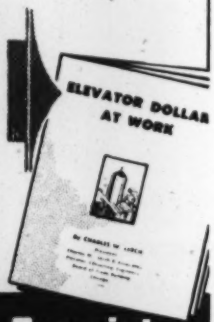

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PERSONNEL MANAGER for Dietary Dept. of 375 bed general hospital with central tray service. Some food service experience essential. Good salary and vacation. 40 hour week. Write Chief Dietitian, Huron Road Hospital, East Cleveland 12, Ohio.

POSITIONS WANTED

DIRECTOR OR ASSISTANT—of Hospital or Clinic. 3 years experience as State College Accountant-Bursar-Business Manager; 6 years State College business teaching. B.A. and M.A. degrees in Business Administration, Iowa University. Wife an R.N., Iowa. Address Box E-1, HOSPITALS.

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Ann Woodward, Director
185 N. Wabash, Chicago 1

When in need of medical or lay administrative personnel, or diplomates of the specialties to head departments, please write for recommendations of qualified candidates. Strictly confidential.

ADMINISTRATOR: Medical; degrees from leading schools; six years, assistant director, university hospital; five years, administrator, important voluntary general hospital, 450 beds; FACHA.

ADMINISTRATOR: Lay; B. S.; Master's, Hospital Administration; two years, assistant administrator, university hospital; currently, administrator, 100 bed voluntary general hospital. Nominee, ACHA.

ADMINISTRATOR: B.S., Business Administration; B.S., Education; C.P.A.; Master's, Hospital Administration; 4 years, director, voluntary general hospital, 150 beds; currently, administrator, important research, medical center hospital. Member, ACHA.

COMPTROLLER: C.P.A.; Ten years, consultant, Blue Cross and all affiliated hospitals, same period, audits, voluntary general hospital, 500 beds.

PATHOLOGIST: Diplomate, Pathologic Anatomy, Clinical Pathology; seven years, director, pathology, university hospital; two years, assistant professor, pathology, university medical school.

DIRECTOR OF NURSES: B.S.; Master's, Abnormal Clinical Psychology; one year, director, psychiatric nursing program and assistant professor, important school of nursing; seeks nursing administration or education psychiatric hospital with university affiliations; early thirties; single.

INTERNIST; Seeks institutional appointment in chest diseases with opportunity medical school research and teaching; M.D. degree, Johns Hopkins; Certified; highly qualified in gastroenterology and bronchoscopy; two years, Chief, all chest services and acting Chief, medicine, 2,000 bed Army hospital; currently, Chief, chest service important VA hospital; licensed, New York; New Mexico; age 39.

THE MEDICAL BUREAU
Burneice Larson, Director
Palmolive Building
Chicago, Illinois

ACCOUNTANT: B.S. (Accounting and Economics) six years, accountant, 600-bed hospital.

ADMINISTRATOR: AB (Economics); BA (Business Administration); BS (Education); MA (Hospital Administration); certified Public Accountant; four years' college teaching; five years, public accounting; eight years, hospital administration; past several years, executive director, important medical center.

ADMINISTRATOR — Graduate nurse; M.B.A. (Hospital Administration); assistant administrator, 400-bed hospital, three years; director, 150-bed hospital unit, university group, four years.

ADMINISTRATOR — Medical; graduate training (D.P.H.) and several years' successful experience, public health field before specializing Hospital Administration; ten years, superintendent, university hospital, 600 beds; regarded as one of outstanding administrators of the country.

PHARMACIST: B.S. in Pharmacy, one of leading universities; two years experience as hospital pharmacist, three years staff pharmacist, teaching hospital.

PATHOLOGIST: Diplomate; three years, assistant professor of pathology, medical school and associate director, its teaching hospital; since 1947, director of pathology, 350-bed hospital.

PERSONNEL DIRECTOR: M.A.; considerable work towards Ph.D.; six years, personnel director in industry; three years, personnel director, 350-bed hospital.

PUBLIC RELATIONS DIRECTOR: B.S. degree; nine years, director, public relations, 350-bed hospital.

RADIOLOGIST. Diplomate. Fellow American College of Radiology; seven years, director, radiology, 300-bed hospital; now associated with radiological group; prefers directorship, hospital department.

INTERSTATE
MEDICAL PERSONNEL BUREAU
332 Bulkley Building, Cleveland, Ohio
Miss Elsie Dey, Director

NURSE SUPERINTENDENT: Graduate Pennsylvania hospital. 5 years Superintendent, 50 bed hospital, Virginia; 4 years 60 bed hospital, Maryland.

ADMINISTRATOR: Graduate Ohio State University Business Administration. 5 years Public Accountant. 10 years Business Manager. 165 bed mid-western hospital. Desires change. Well recommended.

COMPTROLLER: C.P.A. Degree. 4 years Senior Accountant, eastern firm. 2 years Comptroller, 500 bed hospital. Pennsylvania. Will consider assistantship.

ADMINISTRATOR: Banking experience. 5 years present position, Business Manager, 120 bed eastern hospital. Desires Southwest.

HOUSEKEEPER: Course in Institutional Management, 5 years experience, eastern hotels. 4 years executive housekeeper, 250 bed hospital.

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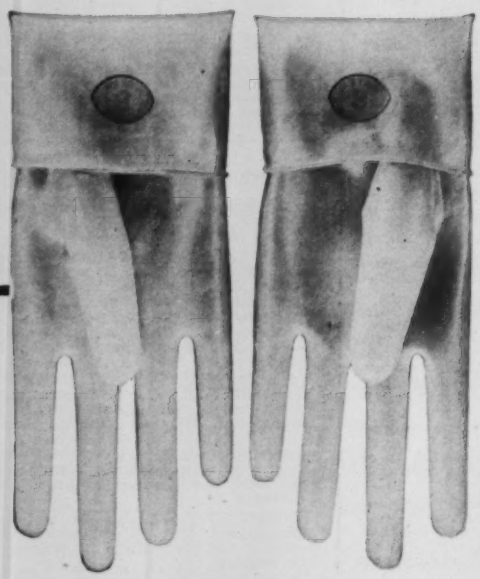

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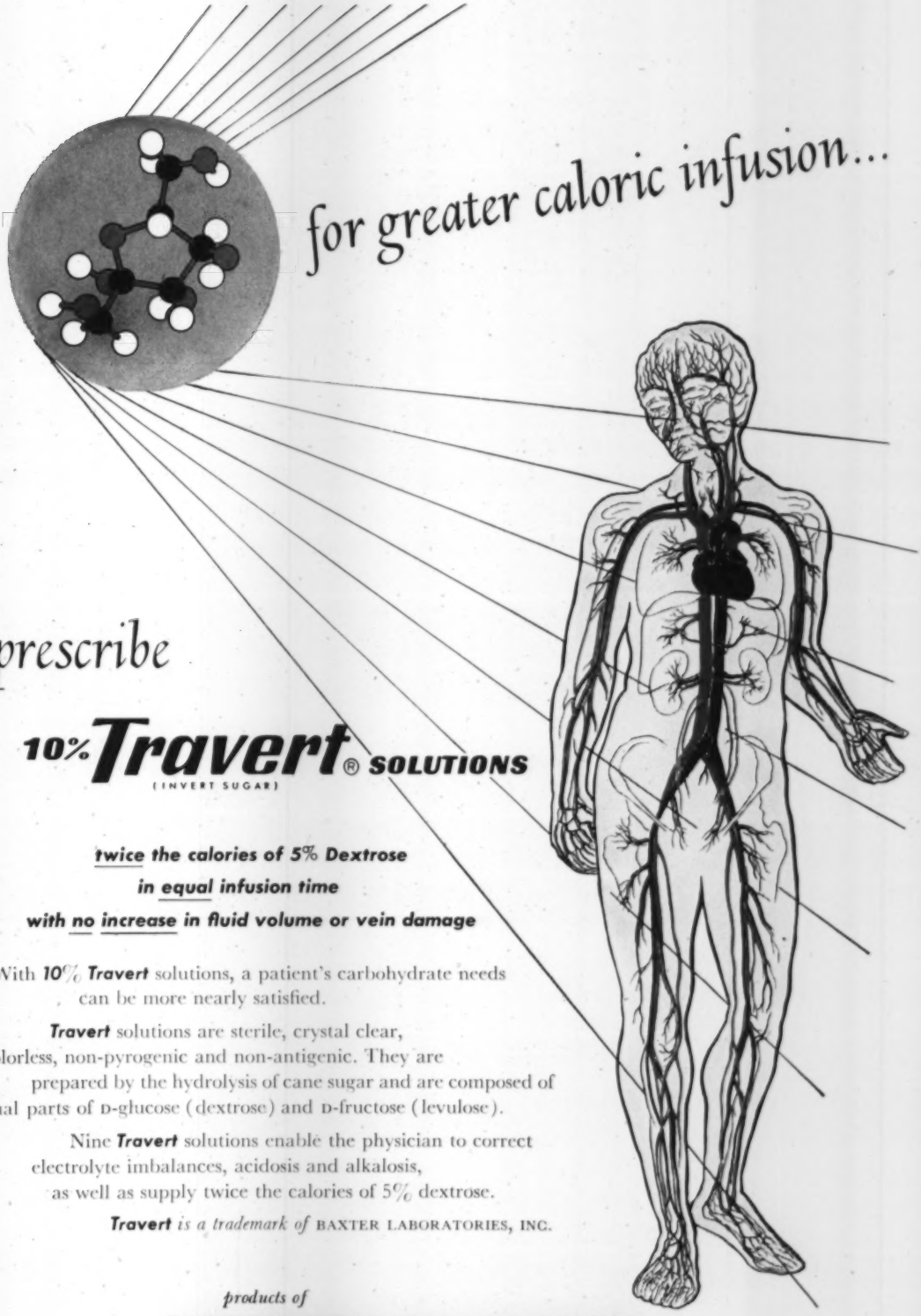

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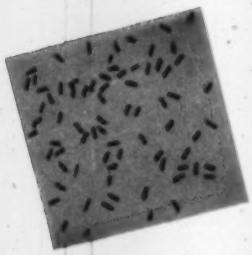

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